## ARTICLE 8. HEALTH SERVICES

**Section 1400. Responsibility for Health Care Services.**

**The facility administrator shall ensure that health care services are provided to all minors. The facility shall have a designated health administrator who, in cooperation with the facility administrator and pursuant to a written agreement, contract or job description, is administratively responsible to:**

**(a) develop policy for health care administration;**

**(b) identify health care providers for the defined scope of services;**

**(c) establish written agreements as necessary to provide access to health care;**

**(d) develop mechanisms to assure that those agreements are properly monitored; and,**

**(e) establish systems for coordination among health care service providers.**

**When the health administrator is not a physician, there shall be a designated responsible physician who shall develop policy in health care matters involving clinical judgments.**

**Guideline:** This regulation applies to all juvenile facilities and establishes the facility administrator with the ultimate responsibility for ensuring that health care is provided to all minors. Health care encompasses a wide range of services associated with providing medical, mental health and dental care.

In facilities providing on-site health care services, a health care administrator must work in cooperation with the facility administrator to develop health care policies that are consistent with the scope of services **(Section 1402, Scope of Health Care)**. The health administrator's responsibilities include identifying service providers, establishing and monitoring necessary agreements and coordinating services among providers to facilitate cooperative relationships. This individual should advocate for health services at a broad level within the system. When developing administrative policies and procedures, this administrator should adopt a collaborative approach that incorporates input from relevant supervision and health care staff, together with other agencies that may be affected by the decisions.

The regulation requires that a responsible physician develop policy and procedures related to the clinical aspects of health care. While the health administrator and responsible physician may be the same person, some systems may have a non-physician as an administrative head for health policy. When this occurs, a physician must also be identified as having responsibility for clinical policy. This sets a policy-level basis for clinical independence in patient care decisions while keeping administrative policy within the purview of the facility administrator **(Section 1401, Patient Treatment Decisions)**. Many situations require a close working relationship between the health administrator and responsible physician, as there are both clinical and administrative aspects of the same issue.

As discussed in **Section 1402, Scope of Health Care**, the extent and manner of delivering health care services will vary among facilities, with some facilities providing all or most of their health care "off-site." While **Section 1400** requires a responsible physician, this individual does not necessarily need to be an employee of the facility. The physician may be available pursuant to a written agreement, contract or job description. For example, when a facility has a health care agreement with a local hospital, the "responsible physician" may be the director of emergency services at the hospital and the agreement or the hospital's position description could identify responsibilities associated with clinical policy for the juvenile facility with that director.

## Section 1401. Patient Treatment Decisions.

**Clinical decisions about the treatment of individual minors are the sole province of licensed health care professionals, operating within the scope of their license and within facility policy defining health care services.**

**Security policies and procedures that are applicable to child supervision staff also apply to health care personnel.**

**Guideline:** Licensed health care professionals, operating within the scope of practice defined by their license, have the sole authority to make clinical decisions for individual minors under their care. Those decisions must be consistent with facility health care policy. When there are policy conflicts among supervision and health care staff, the health administrator would be expected to be the administrative voice for health care. This individual would also coordinate efforts and resolve conflicts among health care disciplines.

The unique environment of these facilities is also addressed by clarifying that health care staff is subject to the same security policies and procedures as supervision staff. It envisions a cooperative relationship between child supervision and health care providers. This cooperation is essential because it takes the expertise of both to maintain order, assure safety and provide health care and programs in a detention facility.

Health care staff should receive training on supervision and security policies for which they are held accountable and within which they are expected to function (e.g., key control, lockdown, transportation security, etc.). Likewise, child supervision staff needs to understand the duties and responsibilities of health care providers. Transport security is the responsibility of supervision staff; however, minors need to be transported to off-site providers in a timely manner when directed by the authorized health care staff. The failure to transport to a designated health care appointment can be interpreted as not following patient treatment directives.

## Section 1402. Scope of Health Care.

**(a) The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to define the extent to which health care shall be**

**provided within the facility and delineate those services that shall be available through community providers. Each facility shall provide:**

**(1) at least one physician to provide treatment; and,**

**(2) health care services which meet the minimum requirements of these regulations and be at a level to address acute symptoms and/or conditions and avoid preventable deterioration of health while in confinement.**

**(b) When health services are delivered within the juvenile facility, staff, space, equipment, supplies, materials, and resource manuals shall be adequate to the level of care provided.**

**(c) Consistent with security requirements and public safety, written policy and procedures for juvenile facilities and jails shall provide for parents, guardians, or other legal custodians, at their own expense, to authorize and arrange for medical, surgical, dental, mental health or other remedial treatment of minors that is permitted under law.**

**Guideline:** This regulation applies to all juvenile facilities and requires health and facility administrators to define the scope of services provided within the facility and by community resources. Juvenile facilities are a "catchment" point for important health care interventions and prevention. The minor's health care in the facility should be part of a continuum that extends into the community upon release.

It is critical that immunizations, comprehensive health appraisals, medical exams and related testing be incorporated into juvenile health care. Because all needs cannot be anticipated or specified in regulation, it is required that health care be at a level necessary to address acute symptoms and/or conditions and avoid preventable deterioration of the minor's health while confined. It is important that health care services respond to "symptoms" such as pain, even though those symptoms may not be readily associated with an identifiable condition. The decisions about what care is "necessary" may relate to the anticipated length of stay. Some health care interventions are better handled in the community upon release.

This broad spectrum of health care services must be addressed in facility policies and contracts with private providers. The regulation does not require that all agreements necessarily be in writing; however, both written contracts with private providers as well as interagency memorandums of understanding (MOUs) provide greater assurance that there is a clear understanding of expectations and coordination of services within the delivery system. Mechanisms for monitoring contracts need to be established in coordination with the facility administrator and consistent with county policies.

Health care services must meet the needs of detained minors and be consistent with community standards, but this regulation allows considerable latitude for administrators to determine how health care will be provided. Factors to consider when designing service delivery systems for each facility include: the type of facility and population held (e.g., juvenile hall, special purpose juvenile hall or camp); available physical space to provide care (e.g., exam rooms, interview space and health care housing); proximity to local hospitals and emergency services; together with staff time and transportation costs associated with taking minors off-site for care.

It is important to have the necessary staff, space and support for health care programs, if services are to be delivered effectively. While these considerations are relevant for planning services at any time, they are particularly critical when planning for new construction. The **Needs Assessment Study [Title 24, Section 13-201(c)2]** and the **Program Statement [Title 24, Section 13-201(c)3]** for new construction provide an early opportunity to determine what services will be provided on site, and which ones will be provided in the community.

Responding to certain key questions will help determine the appropriate staffing level for nurses, mental health workers, dentists and other health services staff:

1. *What is the Average Daily Population (ADP)?* The ADP may be higher than the "maximum capacity" and medical coverage should address the true population. This requires that the ADP (and the ADP projections, if planning for the future) be broken down into specific subcategories by service needs. For example: number of minors requiring special mental health housing; number requiring other mental health services; number requiring dental care, number of emergencies per month; number of requests for minor medical attention; number of minors per month exhibiting signs of depression etc., which might require suicide prevention monitoring.

2. *How many minors are receiving medication?* This question will also help when determining the level of pharmaceutical staffing or the extent of the pharmaceutical contract.

3. *What is the facility design?* Are services delivered to the housing units or do minors report to a central clinic area?

4. *What is the level of security in the institution?* In a lower security area, minors can present themselves to a central location and move through a line rapidly. In a high security area, a nurse may go to each housing area, thus increasing staff time.

5. *What is the child supervision staffing level?* Health personnel may require custody escort. If that staffing is limited, this can mean health providers are delayed in carrying out their duties, thus further increasing the number of health care providers necessary.

6. *What other programs are present in the facility?* How many minors require frequent court appearances? If these minors are taking medications, this may mean increased staffing is necessary during peak hours and could vary greatly if all the residents are post adjudicated.

7. *How many tasks are performed during sick call and "pill" call?* More tasks mean more time in a unit, but perhaps fewer interruptions through the day.

The health authority and the facility administrator should explore these questions jointly and determine an appropriate staffing level. In addition to physical space requirements, personnel considerations will help determine if it is most viable to:

1. hire medical personnel to work in the facility as employees of the probation department;
2. contract with a local hospital, private physician, private psychiatrist, medical group, health maintenance organization, or medical center;
3. develop a written agreement with the county health department to provide health care;
4. develop a regional agreement among several small counties to provide "roving physicians" and support personnel; or,
5. develop some other method of ensuring provision of health services in the most effective and cost efficient manner possible for a facility and/or system.

While services of licensed professionals who are not physicians can be utilized, the regulation incorporates the minimum requirement that at least one physician be available to provide treatment. This assures that not only is there a physician designated for clinical policy (the responsible physician identified in **Section 1400, Responsibility for Health Care Services**) but also one who is available to provide patient care. This can and often will be the same individual. Physician(s) can provide services on-site or, pursuant to policies and procedures, be available via transport to a local emergency room, a local physician's office or other facilities providing health care within the detention system.

The regulation requires procedures to allow parents, guardians or other legal custodians to make off-site arrangements for health care. It clarifies that this care would be at their own expense and with consideration for security and public safety. These procedures should incorporate the participation of probation staff.

**Section 1403. Health Care Monitoring and Audits.**

**(a) In juvenile facilities with on-site health care staff, the health administrator, in cooperation with the facility administrator, shall develop and implement written policy and procedures to collect statistical data and submit at least annual summaries of health care services to the facility administrator.**

**(b) The health administrator, in cooperation with the responsible physician and the facility administrator, shall establish policies and procedures to assure that the quality and adequacy of health care services are assessed at least annually.**

**(1) Policy and procedures shall identify a process for correcting identified deficiencies in the medical, dental, mental health and pharmaceutical services delivered.**

**(2) Based on information from these assessments, the health administrator shall provide the facility administrator with an annual written report on medical, dental, mental health and pharmaceutical services.**

**(c) Medical, mental and dental services shall be reviewed at least quarterly, at documented administrative meetings between the health and facility administrators and other staff, as appropriate.**

**Guideline:** Health care issues are a frequent point of litigation and represent a substantial portion of budgets. Facility administrators rely on health care providers to keep them apprised of concerns and recommended resolutions. The intent is that facilities develop internal procedures to assess the quality and adequacy of their services, identify and resolve problems, and assure that the facility administrator, who is ultimately responsible to ensure that services are delivered, is systematically apprised of problems and concerns.

The regulation is applicable to all facilities with on-site health care staff, however limited those services. It applies regardless of whether they are funded through the detention budget, are city or county employees, or are private providers working in the facility. The regulation does not apply to facilities that rely only upon an emergency room or community physicians to provide services outside the facility. These licensed providers would have their own internal mechanisms for monitoring and quality control. This limitation not withstanding, it may be useful for administrators to prepare statistical summaries on outside health care services to assure oversight of related costs.

The health administrator is responsible to develop the reporting procedures and a system for maintaining the statistics that assist in the future planning, cost control and identifying changes in patterns of providing service. For example, information regarding excessive use of specialty clinics may be used as support to hire a specialist to hold on-site clinics, or high rates of emergency department utilization may justify the addition of on-site health staff to improve coverage at the facility.

The content of the statistical data collection and summaries should be developed with input from both supervision and health care staff. It should reflect the needs and operation of each facility; however, the following list suggests several considerations:

- Sick call visits
  - by physician assistant/nurse practitioner
  - by nursing staff
  - by physicians
- Child abuse reports
- Treatment for accidents/fights
- Health appraisals/medical examinations
- Mental health evaluations
- Referrals to mental health services
- Health care services arranged by parent/guardian
- Substance abuse identified
- Transport services (ambulance/car)
- Laboratory tests performed
- Pharmacy services
- Types and numbers of communicable diseases diagnosed
- Emergency department visits
- Specialty clinic services
- Pregnancies identified
- Diagnostic services (laboratory, x-ray, EKG, etc.)
- Profile of hospital and mental health admissions
- Dental services
- Suicide attempts

The health administrator must submit a report, at least annually, to the facility administrator. This report is to outline statistical data on the frequency of services provided and highlight problems identified by the internal process that assess the quality and adequacy of clinical services. The report should analyze the data to identify trends and, in addition to including recommendations for resolving identified problems, it should give the administrator an overall understanding of issues facing the health services system. Established mechanisms should assure that the facility administrator is aware of significant issues related to providing health care and that problems are resolved promptly.

Internal mechanisms for assuring ongoing consistency, quality and adequacy of the services need to be developed with the responsible physician, as there are significant clinical implications. Monitoring of internal quality control is central to this regulation. Even though only annual assessment reports are required, quality review and control must occur on an ongoing basis. Except in unusual circumstances, this process of internal quality assurance can be accomplished only by on-site monitoring, and it is recommended this ongoing monitoring be documented as an internal quality assurance report. The importance of incorporating pharmaceutical services into the monitoring and audit process should be emphasized **(Section 1438, Pharmaceutical Management).**

Quality control documentation should be considered a health care function and should be maintained within the health care services unit. While medical records are probably the main source, other possible means of generating audit information include:

1. studying outbreaks of illness such as diarrhea, flu, etc. (e.g., morbidity review);
2. studying deaths in custody (e.g., mortality review);
3. individual case review;
4. monitoring activities of clinical staff (e.g., review of use of restraints, seclusion, etc.);
5. review of similar diagnoses (e.g., all diabetics);
6. review drug use (e.g. psychotropics, antibiotics, narcotics, etc.);
7. review of policies and practices;
8. study of all suicides and attempts;
9. liability claims review;
10. data obtained from incident reports, together with staff interviews and observations of health care services;
11. review of implementation and status of standing orders; and,
12. review of minors' complaints.

Health and facility administrators are to discuss health care issues at least quarterly in documented administrative meetings. This does not preclude them from delegating this responsibility or including additional personnel. Neither does it require that meetings be solely dedicated to health care. While meetings among line-level child supervision and health care staff are critical for effective service delivery, this regulation focuses on administrative, policy level personnel and communication systems that contribute to problem resolution.

**Section 1404. Health Care Staff Qualifications.**

**(a) The health administrator shall, at the time of recruitment for health care positions, develop education and experience requirements that are consistent with the community standard and the needs of the facility population.**

**(b) In all juvenile facilities providing on-site health care services, the health administrator, in cooperation with the facility administrator, shall establish policy and procedures to assure that State licensure, certification, or registration requirements and restrictions that apply in the community, also apply to health care personnel who provide services to minors.**

**(c) Appropriate credentials shall be on file at the facility, or in another central location where they are available for review. Policy and procedures shall provide that these credentials are periodically reviewed and remain current.**

**(d) The health administrator shall assure that position descriptions and health care practices require that health care staff receive the supervision required by their license and operate within their scope of practice.**

**Guideline:** This regulation applies to all facilities with on-site health care staff and clarifies that licensing, certification and registration requirements in the community also apply to those who provide services to minors in the facility. The health administrator must ensure that medical and mental health services are provided by qualified staff working within the scope of their license or certification as defined in the **Business and Professions Code**. There is a potential for criminal prosecution if providers perform procedures beyond those allowed by their licenses, and individuals can lose their licenses for doing so. Health care personnel working in the facility must:

1. have appropriate and valid California licenses and/or are certified to provide care;
2. work within the scope of practice described by their particular license or certificate; and,
3. keep their licenses and/or certificates current.

While the task of verifying the validity of licenses and/or certificates may properly belong to the health administrator, the facility administrator should participate in the development of the written policies and procedures for verification. These policies and procedures should require: that the license be presented to the health administrator for inspection; that it be reviewed, verified and recorded; that special note be made of the requirements for renewal; and that a schedule is set up for the appropriate periodic inspection. This information, along with a copy of the licensing or certification credentials, is to be kept on file in the facility or, in a multi-facility system, at a central location where they are available for review. Written verification procedures can include requests for copies of educational certificates and course content.

The State Department of Consumer Affairs can assist in determining which categories of health personnel are licensed and which can practice under protocols, standardized procedures, and/or

standing orders from a responsible physician. Consumer Affairs can also provide copies of the various scope of practice categories such as the **Nurse Practice Act**, help determine the scope of practice for each licensure and certification category and, through its legal staff, help clarify the complex and sometimes baffling issues surrounding use of allied health personnel. (**See Appendix 1** for a list of various health care organizations and licensing boards.)

The regulation also requires that when facilities recruit for health care positions, they solicit individuals who not only have the required credentials, but also have experience and training that are consistent with what would be expected in similar health care settings in the community. To the degree possible, their backgrounds should be relevant to adolescent populations and meet the facility's needs. Background checks on employees are important to protect the minor's health and to protect the facility from liability. With the exception of proper credentials, the regulation stops short of specifying who can be hired, recognizing that there are often limitations to the pool of applicants. Many juvenile facilities are providing primary care clinics by default, for large numbers of youths. These clinics are critical "catchment" areas for identifying and treating health conditions that would not otherwise be identified until they became increasingly debilitating. It is important that the level, as well as qualifications of the health care staff, reflects the sophistication and training necessary to function as diagnostic and treatment centers for medical, dental and mental health problems.

This regulation is not intended to limit the appropriate use of volunteers or other non-licensed individuals who perform services that would not require licensing or other credentials in the community. These programs need to be supervised and monitored. The "rehabilitation model" in mental health services requires that non-licensed staff be appropriately supervised by properly licensed personnel. The absence of this supervision would present a serious liability to the facility. Mental health programs cannot rely solely on non-licensed staff.

Health care staff must complete the required continuing education to maintain their licenses. This continuing training requirement is essential to maintain the quality of care necessary in the facility. Facility and health administrators should provide whatever support possible to help staff maintain their credentials, particularly with respect to educational opportunities that are relevant to the juvenile population being served.

## Section 1405. Health Care Staff Procedures.

**The responsible physician for each facility providing on-site health care may determine that a clinical function or service can be safely and legally delegated to health care staff other than a physician. When this is done, the function or service shall be performed by staff operating within their scope of practice pursuant to written protocol, standardized procedures or direct medical order.**

**Guideline:** Whenever the responsible physician determines that a clinical function or service can be safely and legally delegated to health care staff other than a physician, it must be performed by staff operating within their scope of practice pursuant to a written protocol or medical order. The responsible physician writes protocols or orders to non-physician health care

providers for the specific treatment of identified minors, self-limiting conditions and for on-site treatment of emergencies. While these orders allow for flexibility, they must occur within the parameters of statute and the facility's clinical policies. Nothing in this regulation prohibits health care staff from independently performing functions that are within their scope of practice.

This regulation relates to protocols, which must be distinguished from direct orders. Direct orders are those from a physician to qualified medical personnel, allied health personnel or medically trained corrections staff that instruct them to carry out a specific treatment, test or medical procedure on a given patient. Protocols refer to the procedure to be followed when performing a clinical function.

A physician should delegate services only if the designated staff is properly:

1. qualified and legally permitted to perform such service;
2. trained in the provision of such services; and,
3. trained in the appropriate procedures for ensuring safety and confidentiality.

Whenever the physician determines that a clinical function can be safely delegated, that function must be performed pursuant to a protocol that:

1. is in writing, dated and signed by the physician in charge (The medical administrator and/or nursing administrator should also sign the protocol);
2. specifies and outlines the procedure to be performed;
3. establishes the required training for personnel initiating the protocol;
4. establishes the method for evaluating continued competence of persons authorized to perform clinical functions;
5. states the limitations or conditions/settings in which protocols may be performed; and,
6. is reviewed and updated at least annually.

Since most facilities will not have a physician on duty in the facility 24 hours a day, seven days a week, protocols and direct orders will be a crucial part of medical service delivery. Practice and procedure must be consistent with accepted medical professional standards and scope of practice.

**Section 1406. Health Care Records.**

**In juvenile facilities providing on-site health care, the health administrator, in cooperation with the facility administrator, shall maintain complete individual and dated health records that include, but are not limited to:**

**(a) intake health screening form;**

**(b) health appraisals/medical examinations;**

**(c) health service reports (e.g., emergency department, dental, psychiatric, and other consultations);**

**(d) complaints of illness or injury;**

**(e) names of personnel who treat, prescribe, and/or administer/deliver prescription medication;**

**(f) location where treatment is provided;**

**(g) medication records in conformance with Title 15, Section 1438;**

**(h) progress notes;**

**(i) consent forms;**

**(j) authorizations for release of information;**

**(k) copies of previous health records;**

**(l) immunization records; and,**

**(m)laboratory reports.**

**Written policy and procedures shall provide for maintenance of the health record in a locked area separate from the confinement record. Access to the medical/mental health record shall be controlled by the health administrator and shall assure that all confidentiality laws related to the provider-patient privilege apply to the health record. Minors shall not be used to translate confidential medical information for other non-English speaking minors.**

**Health care records shall be retained in accordance with community standards.**

**Guideline:** This regulation is to assure that formal medical records are established and their confidentially is maintained in facilities that provide on-site health care services. Written policy and procedures must address the content of health care records, their separation from the confinement record and controlled access only by authorized personnel. While the content of the medical record may vary, it should contain all information relative to the minor's health care from the intake health screening **(Section 1430, Intake Health Screening)**, through health appraisals/medical examination **(Section 1432, Health Appraisals/Medical Examinations)**, requests for health care services **(Section 1433, Requests for Health Care Services)** and all contact with medical and mental health services.

A combined medical, dental and mental health record is encouraged; however, there is a need for a separate, identifiable section for mental health services, whose release is governed by different statutes. Despite unique charting requirements, mental health information should be available in

the medical record. This is especially true with respect to prescribed medications. A combined record promotes continuity and consistency. If a minor is detained on successive occasions, existing health care records should be reactivated whenever possible.

The problem oriented medical record format should be considered, but whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the juvenile system. The record is to be complete and all findings recorded, including notations concerning psychiatric, dental, emergency department and other consultative services. It is important, from a liability standpoint, that records reflect the time as well as date of health care encounters. In instances where encounters take place away from the usual treatment area, the place of encounter should be documented as well.

The confidential relationship of provider and patient extends to minors. The principle of confidentiality protects the minor from disclosure of confidences entrusted to a health care provider during the course of treatment. Thus, it is necessary to maintain health record files under security, completely separate from confinement records and inaccessible to child supervision staff. The health administrator should coordinate with the chief probation officer and juvenile court to develop procedures that assure compliance with various laws relative to confidentiality, release and disclosure of health care records.

A separate file for health records is not necessarily established on every minor. Even in facilities with on-site health care staff, some minors will not be in the facility long enough to require the 96-hour health appraisal/medical examination and will not have any conditions that come to the attention of health care staff. The initial receiving screening form is not a confidential document unless facility policies incorporate evaluations by health care staff into this screening. Any health intervention after the initial screening requires the initiation of a health care record.

While the intake health screening form is mentioned as being included in the medical records, it is also a supervision document and is found in confinement records as well. Some systems develop the screening instrument as a "multiple copy" form for this distribution. The screening form itself is usually based on a minor's self-report and staff observations. Follow-up screening or intervention by health care staff is confidential within the medical record. The intake screening form is administered as part of the intake process and can be completed by trained supervision staff pursuant to a procedure approved by the responsible physician. Some larger facilities may utilize licensed medical staff to complete the form, but where this occurs, it does not necessarily imply that it is a confidential medical document. Its purpose is to detect problems that might require immediate referral to an emergency room or hospital for a clearance, might require separation within the facility for safety reasons, or might influence classification and housing. If medical staff completes the intake health screening, and if the screening form itself is not forwarded to supervision staff, then information needed for proper classification, housing and management must be communicated to supervision staff by some other established means.

Facilities that do not have on-site health care staff should not have access to health care information considered part of the confidential medical record. However, facilities without licensed health care staff will have non-confidential physician's orders instructing child

supervision staff about care of the minor. Those instructions are not protected by the same level of confidentiality as the health care record and are not covered by this regulation.

**Section 1407. Confidentiality.**

**For each jail and juvenile facility that provides on-site health services, the health administrator, in cooperation with the facility administrator, shall establish policy and procedures, consistent with applicable laws, for the multi-disciplinary sharing of health information. These policies and procedures shall address the provision for providing information to the court, child supervision staff and to probation. The nature and extent of information shared shall be appropriate to treatment planning, program needs, protection of the minor or others, management of the facility, maintenance of security, and preservation of safety and order.**

**Guideline:** Confidentiality laws protect the exchange of information and written documentation of medical and mental health treatment from unauthorized disclosure. For this reason, written records of medical, mental health and substance abuse treatment are maintained separate from the confinement record, and kept secure to prevent unauthorized disclosure. Confidentiality protections further extend to prohibit verbal discussions of this material.

In the case of juveniles, the additional role of a parent or guardian makes management of confidential information complex. For most routine general health care, parents have the right to be aware of (and give consent to) examinations and treatment of the minor. Furthermore, it is the parent who generally authorizes providing copies of heath care records to others. However, it is important to know that a variety of statutes protect the privacy of minors who seek treatment for certain types of conditions such as pregnancy, contraception, sexually transmitted diseases, mental health treatment (excluding psychotropic medications) and substance abuse counseling. In such cases, parents/guardians do not have access to the medical record information, nor can they authorize disclosure to a third party. A simple rule of thumb is to assume that in those cases where the minor has legal authority to consent to treatment, control of the medical record information lies in the hands of that minor. When parental consent is required, the parent has authority with respect to medical record disclosure.

Because the laws in this area are numerous, it is recommended that each facility consult legal counsel in formulating its policy on confidentiality issues and in dealing with any case where there is a question regarding confidentiality. Laws relating to confidentiality of records include **Welfare and Institutions Code, Sections 5328, et seq., 18961, 369**, and **739; Civil Code, Sections 798, et seq., 56, et seq.; Family Code, Sections 6910, et seq.; Evidence Code, Section 1013.5; Code 42 of Federal Regulations, Section 2.1, et seq.;** and **Health and Safety Code, Section 1795.**

Juvenile facilities are unique in that management of minors often places supervision staff in a "parent-like" role. It is recognized that sharing of health-related information with supervision staff can be to the benefit of the minor and allows for a comprehensive, multi-disciplinary team approach. A certain amount of health-related information can be shared with facility staff and

the probation officer without obtaining explicit consent of the parent or minor. This is limited to facts that necessarily must be shared in order to safely and properly manage the minor within the facility, or to plan for future placement and programming and not for prosecution. It is important to limit the sharing of this type of information to that which is directly relevant to the stated purpose. Further elaboration would require specific consent. The greatest flexibility in releasing information occurs with a signed consent.

It is also vital that policy and training approaches assure that health care staff are made aware of the necessity to share any information, regardless of the setting in which it was obtained, if it indicates a serious threat to facility security, safety or order.

**Section 1408. Transfer of Health Care Summary and Records.**

**The health administrator, in cooperation with the facility administrator, shall establish written policy and procedures to assure that a health care summary and relevant records are forwarded to health care staff in the receiving facility when a minor is transferred to another jurisdiction, and to the local health officer, when applicable. Policies shall include:**

**(a) a summary of the health record, or documentation that no record exists at the facility, is sent in an established format, prior to or at the time of transfer;**

**(b) relevant health records are forwarded to the health care staff of the receiving facility;**

**(c) advance notification is provided to the local health officer in the sending jurisdiction and responsible physician of the receiving facility prior to the release or transfer of minors with known or suspected active tuberculosis disease;**

**(d) written authorization from the minor and/or parent-legal guardian is obtained prior to transferring copies of actual health records, unless otherwise provided by court order, statute or regulation having the force and effect of law; and,**

**(e) confidentiality of health records is maintained.**

**After minors are released to the community, health record information shall be transmitted to specific physicians or health care facilities in the community, upon request and with the written authorization of the minor and/or parent/guardian.**

**In special purpose juvenile halls and other facilities that do not have on-site health care staff, policy and procedures shall assure that child supervision staff forward non-confidential information on medications and other treatment orders prior to or at the time of transfer.**

**Guideline:** This regulation requires that a health care summary accompanies or precedes each minor who is transferred to a facility in another jurisdiction. It applies to all juvenile facilities where reception and transfer occur. It does not preclude facilities from having additional

requirements for health care information prior to admission. The intent of the regulation is that facilities convey whatever relevant information they know about the minor's health care needs when the minor is transferred elsewhere. Even though the health appraisal/medical examination typically accompanies the minor, the health summary is important because it provides the most current information related to medication and other treatment. Documentation that there is no health care information needs to be forwarded if there is no health care record at the facility.

This information should accompany the minor prior to or at the time of transport to assure continuity of care and to avoid the duplication of tests and examinations. A consistent summary format should be used to document care provided, medical problems, tests (including tuberculosis), treatments, allergies, immunizations, mental health concerns, suicidal ideation and other relevant information. The transfer summary should not only include the current diagnoses and treatment, but should also indicate if there has been an exposure to communicable disease that requires follow-up observation and/or treatment. This information must be compiled by designated health care personnel at the originating facility and forwarded to the attention of the health care staff at the receiving facility.

Each facility and health administrator must coordinate supervision and health care policies to incorporate procedures assuring that health care staff of the sending facility is notified in advance of transporting minors and that the information reaches health care staff upon arrival at the receiving facility. Advance notification to health care staff is essential if they are to have sufficient time to prepare the summary. Confidentiality can be maintained in various ways, including transporting the information in a sealed envelope, which is designated for health services at the receiving facility. If confidential information is faxed, it is critical that the sending and receiving facilities are aware of the need to maintain the required confidentiality.

For minors transferring to or from facilities without on-site health care staff, child supervision staff would forward and receive available instructions for the minor's treatment requirements. This would normally be non-confidential physician directions for the minor's care and include medication delivery instructions. As relevant, these treatment requirements would also be forwarded from facilities with health care staff; however, more detailed confidential health care records should be sent only to a licensed health care provider.

While universal precautions are recommended at all times, special attention should be given to transport instructions, including additional health safety precautions that should be followed by transporting staff. The importance of procedures for maintaining minors on their medications during transport and upon receipt at a facility cannot be overlooked.

**Health and Safety Code Sections 121361** and **121362** require sending facilities to notify the local health officer and the receiving facility prior to transferring or releasing an adult inmate known or suspect to have active tuberculosis disease. While this statute does not technically apply to local juvenile facilities, this regulation parallels the adult statute and requires advance notification and forwarding a treatment plan on minors, pursuant to procedures established by the local health officer. Incorporating local juvenile facilities into this requirement by regulation not only improves continuity of care, but also increases the level of protection for other minors, staff and the community. Local health officers should have policies, procedures and established

formats for conveying tuberculosis information. The State Department of Health Services, Tuberculosis Control Branch is also available to assist local health departments in developing implementation procedures for this notification.

While summary information forwarded to health care staff does not require a signed release of medical information, it is part of the confidential medical file **(Civil Code Section 56.10)**. Release of additional health records requires consent, unless otherwise provided by court order, statute or regulation. Minors can consent to the release of medical information related to treatment for which they are authorized to consent. (See **Section 1434, Consent for Health Care**, for a discussion of statutes and circumstances that would require a consent to release of confidential information to another health care provider.)

The amount of health care information forwarded to outlying camps or ranches at the time a minor is transferred will depend on the needs of the minor, the level of on-site health care staff at the facility and the local policies and procedures for providing overall health care. In some instances, minors may be brought from the camps to a central facility in the detention system for health care. The primary health record should remain where the health care is provided. Camps, ranches, or other facilities that do not have licensed on-site health care staff, cannot have the confidential medical record. Child supervision staff should, however, receive the health care clearance and any relevant summary information on health conditions that could have an impact on the minor's programming in the new facility. The "clearance" becomes a critical document for child supervision staff. (See **Section 1432, Health Appraisals/Medical Examinations,** for a discussion of this transfer clearance.)

## Section 1409. Health Care Procedures Manual.

**For juvenile facilities with on-site health care staff, the health administrator, in cooperation with the facility administrator, shall develop and maintain a facility-specific health services manual of written policies and procedures that address, at a minimum, all health care related standards that are applicable to the facility.**

**Health care policy and procedure manuals shall be available to all health care staff, to the facility administrator, the facility manager, and other individuals as appropriate to ensure effective service delivery.**

**Each policy and procedure for the health care delivery system shall be reviewed at least annually and revised as necessary under the direction of the health administrator. The health administrator shall develop a system to document that this review occurs. The facility administrator, facility manager, health administrator and responsible physician shall designate their approval by signing the manual.**

**Guideline:** The health care procedures manual is an essential document describing relevant aspects of health services. The health administrator has the responsibility for its development, dissemination and update in all facilities with on-site health care staff. Notwithstanding needs for autonomy in clinical policy and decisions, it is important that the health administrator work

closely with the facility administrator and manager to insure that the policies and procedures of the health care system are consistent with the overall policies and procedures of the facility. The most effective manual will have policies and procedures, not only for every health regulation, but for other matters not covered in standards as well. The health care procedures manual should be a comprehensive document that addresses all areas relevant to providing health care, regardless of whether those areas are governed by regulation. In facilities that do not provide on-site health care services, the facility administrator must assure that relevant emergency policies and procedures, as well as those addressing how health care will be accessed, are in the supervision manual.

Health care policies define both the actual delivery of service and the scope of the facility's responsibility. Care must be taken to be realistic and explicit about each policy and its attendant practice. Policies and procedures that are clearly and completely expressed and properly carried out are the best protection against liability.

Because supervision and health care staff works closely together, the facility administrator should set up a process whereby supervision staff are kept aware of and have input into health care policies, procedures and revisions that have an impact on them. Similar processes need to be in place for health care staff to stay current with supervision policies and procedures. A system should also be established to resolve conflicts between supervision and health care personnel. Early input and collaboration between health care and supervision staff should help ensure that policy and procedures do not create unnecessary conflicts; however, establishing a system for conflict resolution should also be considered.

The health care procedures manual and the related processes and programs must be reviewed at least annually so that they continue to reflect practice and meet the needs of the facility. The intent is that policy and procedure manuals remain current. To accomplish this, facilities may elect to update their manuals more frequently. An effective method for documenting each review and revision should include provision for the date and the signature of the reviewer, facility administrator and responsible physician. There should be a process for disseminating changes and making sure all staff understand and implement revisions.

It is not required that each policy and procedure in the original manual be signed to confirm review. A declaration paragraph can be at the beginning or end of the manual stating that the entire manual has been reviewed and approved, followed by the proper signatures. Alternatively, the detention system can develop another mechanism for documentation. When changes are made to individual policies in the manual, they would need to be initialed and dated by the responsible parties.

Annual review of policies and procedures would, in effect, result in a review of the health care delivery system and programs. This is considered a good management practice. This process allows the various changes made during the year to be formally incorporated into the manual instead of accumulating a series of scattered documents. The process of annual review facilitates decision-making regarding previously discussed but unresolved matters.

**Section 1410. Management of Communicable Diseases.**

**The health administrator/responsible physician, in cooperation with the facility administrator and the local health officer, shall develop written policies and procedures to address the identification, treatment, control and follow-up management of communicable diseases. The policies and procedures shall address, but not be limited to:**

**(a) intake health screening procedures;**

**(b) identification of relevant symptoms;**

**(c) referral for medical evaluation;**

**(d) treatment responsibilities during detention;**

**(e) coordination with public and private community-based resources for follow-up treatment;**

**(f) applicable reporting requirements; and,**

**(g) strategies for handling disease outbreaks.**

**The policies and procedures shall be updated as necessary to reflect communicable disease priorities identified by the local health officer and currently recommended public health interventions.**

**Guideline:** One aspect of maintaining a safe facility is communicable disease control. This begins with recognition of suspected communicable disease and appropriate action to prevent its spread. **Section 1354, Segregation,** and **Section 1430, Intake Health Screening,** address this subject more specifically. Policies and procedures should address a wide range of considerations necessary to a comprehensive approach to the subject, including:

1. intake health screening;
2. identification of relevant symptoms;
3. referral for medical evaluation;
4. treatment responsibilities during detention;
5. coordination with public and private community-based resources for follow-up treatment;
6. applicable reporting requirements; and,[1]
7. strategies for handling disease outbreaks.

This regulation requires that each jurisdiction's local health officer be involved in the development of the communicable disease plan. The local health officer has responsibilities in communicable disease control throughout the jurisdiction, including institutions located within it.

[1] Includes California Code of Regulations, Title 17, Sections 2500-2511, and Health and Safety Code, Section 121070.

In addition, **Health and Safety Code Section 101045** requires the local health officer to conduct an annual inspection of detention facilities, and communicable disease control is an important area to address.

Developing a relationship with the local health officer will bring valuable information and resources to the juvenile facility. The health officer will be able to identify communicable disease priorities of importance to the facility, based on disease statistics collected from the surrounding community population. In addition, the health department will be able to provide valuable technical advice and assistance, both in anticipation and response to communicable disease concerns.

In addition to maintaining facility safety, there is the issue of the individual minor's health. **Section 1432, Health Appraisals/Medical Examinations**, should take into account provision of recommended immunizations and screening (e.g., tuberculosis screening) for communicable diseases for which adolescents are at high risk. Age-appropriate communicable disease education should be provided and is addressed more specifically under **Section 1415, Health Education.**

The benefits of communicable disease management extend to staff, visitors and the local community. Likewise, the communicable disease plan should consider the possibility of infections being introduced through contact with family, visitors and staff. In general, minors should be immunized, educated and treated with their future placement in the overall community in mind.

**Section 1411. Access to Treatment.**

**The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to provide unimpeded access to health care.**

**Guideline:** This regulation applies to all juvenile facilities. It requires policy and procedures for minors to have access to health care. It is critical that neither staff nor other minors prevent individuals from requesting and receiving this care. Unimpeded access applies to minors in lockdown and to those with behavior problems, as well as to those in general housing.

To demonstrate access, minors must be advised of health care options, procedures for requesting care and be able to express concerns about the health care system. Orientation to health care services and procedures for accessing care should be provided by designated staff at the time of the minor's orientation to the facility programs and procedures, in a language and vocabulary that is understandable and age-appropriate for the minor **(Section 1353, Orientation)**. The ability for minors to register grievances about the health care system is incorporated into **Section 1361, Grievance Procedure**.

Access to treatment includes options within the institution and provision for outside appointments **(Section 1402, Scope of Health Care)**. Health care personnel should be the individuals to determine when or if health care should be limited. "Access" for minors implies

that parents or guardians are also aware of the options and procedures. The minor's parent or guardian can also register complaints and obtain resolution about health care services through direct access to facility administrators and court remedies.

**Section 1412. First Aid and Emergency Response.**

**The health administrator/responsible physician, in cooperation with the facility administrator, shall establish facility-specific policies and procedures to assure access to first aid and emergency services.**

**(a) First aid kits shall be available in designated areas of each juvenile facility.**

**(b) The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kits.**

**Child supervision and health care staff shall be trained and written policies and procedures established to respond appropriately to emergencies requiring first aid.**

**Guideline:** The purpose of the first aid kit and procedures is to provide emergency intervention. The first aid kit should contain selected medical supplies that would allow supervision staff to treat minor injuries that do not require attention from health care staff (e.g., band-aids for minor cuts) or provide immediate aid pending arrival of health care staff. This regulation requires physician approval for the contents and location of first aid kits. Staff must understand their responsibilities with respect to providing first aid and have the necessary skills and training to perform these responsibilities. It is important that supervision staff be trained to use items in the kit and that this training be updated regularly to maintain the necessary skills.

The contents of the first aid kit, together with the type of first aid equipment, procedures and necessary training will vary depending upon the need to respond to anticipated types of injuries (e.g., a kitchen first aid kit differs from that of a work camp). Procedures for maintaining the kit should include the steps for inventorying and restocking, and would typically outline roles of supervision and health care staff in this regard.

Some facilities may choose not to have first aid kits available to supervision staff because they have health care staff on the premises 24 hours a day, seven days a week and who are available to provide the "first aid" response. When this is the case, the responsible physician must approve the absence of first aid kits and the **Health Care Procedures Manual (Section 1409)** must describe how this first aid response is to occur. Policies should define supervision and medical staff responsibilities.

The estimated time of arrival of trained emergency medical personnel and the possibility that immediate emergency personnel may not be available should be considered in the facility first aid plan. In the usual detention setting, excluding kitchens or other work crew areas, emergencies that can be anticipated include: bee stings; allergic reactions; fights and/or falls resulting in hemorrhage, sprains or broken bones; and shock resulting from trauma, hemorrhage

or fractures. Facilities need to maintain those supplies necessary to respond to these expected and any other emergencies identified in their written procedures on first aid. Emergency response plans need to include written plans for evacuation of ill or injured youth; designated responsibility for notification of emergency personnel; and pre-determined access routes **(Section 1327, Emergency Procedures)**.

**Section 1413. Individualized Treatment Plans.**

**With the exception of special purpose juvenile halls, the health administrator/responsible physician, in cooperation with the facility administrator, shall develop policy and procedures to assure that health care treatment plans are developed for all minors who have received services for significant health care concerns.**

**(a) Policies and procedures shall assure that health care treatment plans are considered in facility program planning.**

**(b) Health care restrictions shall not limit participation of a minor in school, work assignments, exercise and other programs, beyond that which is necessary to protect the health of the minor or others.**

**(c) Medical and mental health information shall be shared with child supervision staff in accordance with Section 1407 for purposes of programming, treatment planning and implementation.**

**(d) Program planning shall include pre-release arrangements for continuing medical and mental health care, together with participation in relevant programs upon return into the community.**

**Policy and procedures shall require that any minor who is suspected or confirmed to be developmentally disabled is referred to the local Regional Center for the Developmentally Disabled for purposes of diagnosis and/or treatment within 24 hours of identification, excluding holidays and weekends.**

**Guideline:** This regulation addresses the management of minors who have health conditions that may have an impact on their ability to function within the established facility routine or to participate in programs for which they are being considered. Examples range from asthma that may only require special consideration during outdoor physical activities to complex mental, developmental or physical disabilities that have an impact on every level of management of the minor.

In most cases, the health care staff conducting the **Health Appraisal/Medical Examinations (Section 1432)** will identify the need for formal treatment planning. Occasionally, the need will be evident as soon as the minor is admitted to the facility. In either case, it is important to assure that one clearly identified health provider takes responsibility for formulating and coordinating the treatment plan.

The treatment plan should address all aspects of the minor's management that are likely to be impacted by the identified health condition. Examples include: housing; participation in school, sports and work assignments; and eligibility for eventual placement in programs being considered by the juvenile court. Health care providers must also coordinate with supervision staff to incorporate these and other conditions into overall planning **(Section 1355, Assessment and Plan)**.

It is intended that the treatment plan developed by health care staff be shared with facility and probation department staff as one element of a multi-disciplinary approach to the minor. This assumes that there will be a sharing of health-related information to the extent necessary to carry out essential elements of the plan. More extensive disclosure requires specific consent of the minor and/or parent, depending on the nature of the information **(Section 1407, Confidentiality)**. When appropriate for release planning or continuity of care within the facility, family members and community service providers may be consulted during planning. This would typically be done through the probation officer, with sensitivity to family member limitations and any history of abuse.

It is desirable to encourage a minor to participate in unrestricted programming to the degree he or she is capable. Therefore, treatment plan recommendations should not be excessively limiting, and reasonable accommodations to promote participation should be undertaken whenever possible.

In the case of minors who are known or suspected to be developmentally disabled, contact must be made with the local regional center within 24 hours, excluding holidays and weekends. The term "developmentally disabled" technically applies to persons with an I.Q. of 69 or lower, or with epilepsy, autism, or a significant neurological disability that occurred prior to age 18 and resulted in substantial disability. The regional center can be helpful in evaluating minors and contributing to a plan of management. An evaluation can be particularly helpful in cases who have not yet been identified or diagnosed, as such minors may be eligible for special services, both during and after confinement **(Section 1355, Assessment and Plan)**.

## Section 1414. Health Clearance for In-Custody Work and Program Assignments.

**The health administrator/responsible physician, in cooperation with the facility administrator, shall develop health screening and monitoring procedures for work and program assignments that have health care implications, including, but not limited to, food handlers.**

**Guideline:** This regulation requires all juvenile facilities to have procedures for screening, education and monitoring when work assignments have health implications. This includes food service workers and may also include other assignments as identified by the responsible physician. For example, there are implications for minors with allergies, such as bee stings or poison oak, who are assigned to outdoor work crews.

To promote a balance of health, security and practical operational concerns, the responsible physician, in cooperation with the facility administrator and the food services manager, must develop procedures for screening food service workers. A medical screening program for food handlers prior to initial assignment in a facility food preparation or serving area is necessary to minimize exposure of minors and staff to food borne diseases. A food handler is any person who works with food or food preparation utensils in a facility kitchen or area where food is prepared or distributed to minors or staff. Persons who distribute catered, individually packaged meals are exempt from this screening procedure.

It is necessary to have a clear and specific written protocol for screening food handlers, approved by the responsible physician and administered by a staff person trained specifically for this function. At a minimum, the protocol should include the following:

1. the absence of exposure to and symptoms of food borne contagious diseases, especially hepatitis and diarrheal disease by history; and,
2. a physical examination to exclude infected skin lesions, tenderness of the liver and jaundice.

The protocol should include a referral process for follow-up care of minors with a positive finding on the food handler screening. No minor should be assigned to work as a food handler until the medical screening is completed and there should be periodic reassessment of the health status of food service workers. While the protocol under discussion addresses minors, it is recommended that civilian food service employees undergo similar screening prior to starting work as food handlers as well. (**Appendix 2** provides a sample screening form for food service workers.)

In combination with the medical screening, the responsible physician should work in cooperation with the facility administrator and the food service manager to develop written procedures for the ongoing supervision and cleanliness of food service workers in accordance with **Section 1465, Food Handlers Education and Monitoring**.

**Section 1415. Health Education.**

**With the exception of special purpose juvenile halls, the health administrator for each juvenile facility and jail, in cooperation with the facility administrator and the local health officer, shall develop written policies and procedures to assure that age- and sex-appropriate health education and disease prevention programs are offered to minors.**

**The education program shall be updated as necessary to address current health priorities and meet the needs of the confined population.**

**Guideline:** One step in the process of preparing minors to assume responsible and healthful lifestyles is to equip them with accurate information on health issues. Despite any appearance of experience and sophistication that minors may convey, they are frequently misinformed about many aspects of personal health and risk factors for disease.

With the exception of special purpose juvenile halls, this regulation requires that all juvenile facilities work with their local health officer to develop a program of regular health education. Even though special purpose juvenile halls are exempt from this requirement, consideration should be given to including health education as a component of programming for those minors who are committed to these facilities for a series of weekends.

The local health department should be viewed as a resource to assist in planning a curriculum that is age- and culturally appropriate and reflects locally identified health priorities. In addition, the health educator associated with the health department may be able to provide classes within the juvenile facility.

Facilities can be creative in finding various effective and cost-efficient methods for delivering health education services. The State Department of Social Services administers Temporary Aid to Needy Families (TANF) funds, which can be expended for health education programs. Health education can be incorporated into the regular school curriculum, offered in the form of audio or video materials, or provided by some other means that meets the needs of the confined population. For example, some facilities have utilized food services personnel to address the subjects of nutrition and obesity.

Recommended subject areas for inclusion in a health education program include, but are not limited to:

1. chemical dependency, including tobacco use;
2. sexually transmitted diseases;
3. sexuality, including methods of birth control;
4. pregnancy and parenting skills;
5. nutrition;
6. exercise;
7. oral hygiene; and,
8. mental health and suicide prevention.

Regardless of the method of delivery of health education, it is recommended that each facility maintain a record of classes, including the overall plan for what will be offered.

**Section 1416. Reproductive Services.**

**For all juvenile facilities and jails, the health administrator, in cooperation with the facility administrator, shall develop written policies and procedures to assure that reproductive health services are available to both male and female minors.**

**Such services shall include but not be limited to those prescribed by Welfare and Institutions Code Sections 220, 221 and 222 and Health and Safety Code Section 123450.**

**Guideline:** All juvenile facilities must develop policies and procedures to address reproductive services for detained minors. The extent of such services will depend on the length of confinement and eligibility criteria for the facility (e.g., camp facilities may choose to exclude pregnant girls). In any case, all facilities must meet statutory requirements having to do with access to reproductive services.[2]

Procedures must provide for continuation of any contraceptive method that a minor has established prior to admission into a juvenile facility. There is a high liability to facilities when a pregnancy occurs following release of a minor whose contraceptive method has not been continued.

Pregnancy testing should be readily available. When pregnancy is diagnosed, the full range of options for treatment that are available in the community must be offered. These generally include prenatal care, adoption and therapeutic abortion services. Special considerations include requirements for parental consent in the case of a requested abortion **(Health and Safety Code, Section 123400)**.

Health care staff should be sensitive to the possibility of child abuse in the case of diagnosed pregnancy or sexually transmitted diseases. While the presence of one of these conditions in a minor is not sufficient to confirm sexual exploitation, additional information may lead to identification of reportable child abuse that calls for additional interventions.

Other facility policies and procedures should take pregnancy issues into account. One example is the safe use of restraint devices during pregnancy. Some facilities prohibit waist or ankle chains during advanced pregnancy, and allow only for the use of handcuffs in front of the body in order to limit the possibility of abdominal injury in the event of a fall. It is also important to provide for appropriate prenatal diets, including the provision of snacks to assure an adequate frequency of food intake **(Section 1462, Therapeutic Diets)**.

In the open community, minors have access to family planning services without a requirement for parental consent. These services should be similarly available to detained minors. Whenever possible, attention should be given to addressing contraceptive concerns sufficiently far in advance to establish a method that will be fully effective at the time of release.[3] Consideration should be given to making condoms available at the time of release to both boys and girls who request them. Some juvenile facility health programs are designated as a clinic site under the state Office of Family Planning program. In such cases, all program requirements established under the state Department of Health Services would apply.

In addition to offering specific services, juvenile facilities should consider inclusion of education concerning reproductive health. Topics to consider include: nutritional issues; breast feeding; parenting; sexually transmitted diseases; and personal responsibility in reproduction. Whenever appropriate, boys should be included in all aspects of reproductive education and programs.

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[2]Welfare and Institutions Code, Sections 220, 221 and 222; and Health and Safety Code, Section 25958.

[3]Welfare and Institutions Code, Section 221, requires all juvenile facilities to offer family planning services to each female minor at least 60 days prior to a scheduled release date.

**Section 1430. Intake Health Screening.**

**The health administrator/responsible physician, in cooperation with the facility administrator, shall establish policies and procedures defining when a health evaluation and/or treatment shall be obtained prior to acceptance for booking. Policies and procedures shall also establish a documented intake health screening procedure to be conducted at the time of booking each minor admitted to the facility.**

**(a) The responsible physician shall establish criteria defining the types of apparent health conditions that would preclude acceptance of a minor into the facility without a documented medical clearance. The criteria shall be consistent with the facility's resources to safely hold the minor. At a minimum, such criteria shall provide:**

- **(1) a minor who is unconscious shall not be accepted into a facility;**
- **(2) minors who are known to have ingested or who appear to be under the influence of intoxicating substances shall be cleared in accordance with Section 1431;**
- **(3) written documentation of the circumstances and reasons for requiring a medical clearance whenever a minor is not accepted for booking; and,**
- **(3) written medical clearance shall be received prior to accepting any minor referred for a pre-booking treatment and clearance.**

**(b) Procedures for an intake health screening shall consist of a defined, systematic inquiry and observation of every minor booked into the juvenile facility. The screening shall be conducted at the time of booking and may be performed by either health care personnel or trained child supervision staff.**

- **(1) Screening procedures shall address medical, dental and mental health concerns that may pose a hazard to the minor or others in the facility, as well as health conditions that require treatment while the minor is in the facility.**
- **(2) Any minor suspected to have a communicable disease that could pose a significant risk to others in the facility shall be separated from the general population pending the outcome of an evaluation by health care staff.**
- **(3) Procedures shall require timely referral for health care commensurate with the nature of any problems or complaint identified during the screening process.**

**Guideline:** Intake health screening is a process of structured inquiry and observation designed to prevent newly arriving minors who pose a health or safety threat to themselves or others from being admitted to a facility's general population, and providing necessary health care when indicated. It must occur at the time a minor enters the facility and should not be confused with the more comprehensive health appraisal and medical examination, which occurs later, pursuant to **Section 1432, Health Appraisals/Medical Examinations**. This screening regulation establishes the importance of pre-admission screening for observable health care needs that should be identified and addressed prior to acceptance for booking. These minors should be referred for medical clearance prior to acceptance. Minors who are accepted for booking may also present needs for a health care referral. Consequently, the regulation also requires that

referrals be made to appropriate health care staff for evaluation, with prompt and continuous care provided as warranted.

The screening can be performed by appropriately licensed or certified health personnel or by child supervision staff who are trained to administer the intake screening questionnaire. Facility staff must find out at the earliest possible time who is suspected of carrying a contagious disease, who is in need of medical attention and who should not be admitted without a medical/mental health clearance. This process protects the minor, the facility, other minors and staff from both contagious disease and from potential litigation.

The health administrator/responsible physician must work with the facility administrator to establish policy and procedures identifying when minors must have health evaluations and/or treatment prior to acceptance for booking. Policies regarding the condition of minors accepted into the facility are expected to vary depending upon the level of care available on-site. Facilities with 24-hour health care staff may have a different "threshold" for acceptance than facilities without that level of resources. There must also be procedures to document why a minor was not immediately accepted for booking, but was referred for a health clearance. The regulation is silent about whether this health clearance can be conducted by on-site health care staff or if the minor must be referred to a community resource, usually an emergency room or local urgent care center. Either option complies with regulations. Minors who are unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention upon arrival at a facility must be referred immediately for emergency medical care. Additionally, those who are known to have ingested or who appear to be intoxicated must be medically cleared prior to acceptance. Their admission or return to the facility must be based on written medical clearance from the health care provider.

Medi-Cal will reimburse community health care facilities for emergency services, outpatient care and inpatient treatment for Medi-Cal covered detained minors prior to booking and once they are released from custody. Additionally, minors are eligible for Medi-Cal reimbursement while in the facility awaiting placement. The state's definition of "released from custody" is that the individual is no longer incarcerated and includes: home detention with or without electronic monitoring; parole; released for time served; probation; or individuals released on their own recognizance. A stay in sentence is not considered being released from custody for purposes of Medi-Cal reimbursement. Medi-Cal does not pay city and county jurisdictions for needed health care services provided by staff in local detention facilities. Local agencies may wish to review their acceptance for custody policies and their release procedures because of these interpretations of Medi-Cal eligibility.

The findings of the intake health screening are to be recorded on a printed form approved by the responsible physician. (If the screening is automated, provision should be made during programming to accommodate needs for internal quality assurance monitoring.)

A medically licensed or certified person such as a registered nurse, physician's assistant, nurse practitioner or registered nurse may administer the checklist; however, facilities may use nonmedical staff per the written order of the health administrator/responsible physician. Nonmedical personnel must be properly trained by a health practitioner or other qualified

professional in the use of the screening form, symptom recognition and other observations the screener should make, documentation of observations, method of referral and any additional concepts which clarify both facility policy and procedures for receiving minors.

The screening checklist is best administered in a reasonably private setting to increase open communication and improve the chances of the minor notifying staff of any potential problems. The more information garnered through the screening, the better the likelihood that important issues will surface and can be addressed in classification, housing and medical service decisions. Screening forms should be maintained for future reference if the minor is readmitted, but the process itself must be repeated every time the minor is re-booked.

The areas included below are examples of the kinds of questions and observations that may be considered when building a receiving screening process. Each facility should include questions that might be helpful in the management and appropriate treatment of minors. It is important for screening personnel to be trained to identify each detainee's suicide risk and complications associated with drug or alcohol usage. Questions should be asked concerning any history of suicidal or erratic behavior including: delusions; hallucinations; communication difficulties; impaired level of consciousness; disorganization; memory defects; depression; trauma; or evidence of self-mutilation or substance abuse **(Section 1450, Suicide Prevention Program)**. The screening should inquire about medications taken and special health requirements. This includes chronic medical problems necessitating regular maintenance therapy such as insulin for diabetes, seizure medications, inhalers and other treatment for asthma. While screening for STDs is a priority for many facilities, this issue is probably most important at the 96 hour **Health Appraisal/Medical Examinations (Section 1432)**, unless symptoms are identified at the receiving screening. Staff should pay particular attention to signs of trauma and recall the responsibility for reporting all instances of suspected child abuse.

Inquiry:

1. current illness and health problems, including medical, dental, psychiatric history and communicable diseases;
2. medications taken and special health requirements, including chronic medical conditions necessitating regular maintenance therapy;
3. use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use, and a history of complications related to usage;
4. history of suicide attempts and presence of current suicidal ideation;
5. history of developmental disability;
6. inquiry about physical or sexual abuse;
7. for females, a history of gynecological problems, possibility of current pregnancy, and present use of birth control; and,
8. specific inquiry about current symptoms suggesting communicable diseases, such as tuberculosis and sexually transmitted diseases.

Observation:

1. behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating;
2. physical disabilities and ease of movement;

3. condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and evidence of infestations, needle marks or other indications of drug abuse; and,
4. slowness in speech or lack of comprehension of questions, suggesting developmental disabilities.

Facilities should have procedures for obtaining information from a juvenile detainee as to whether the minor is emancipated or living with a parent, guardian or in a foster home. Including this information in the health chart where it is easily accessible may be helpful in the event that consents are needed for medical services. It may prove worthwhile to call the parent, guardian or foster parent for additional health information about the juvenile and to make inquiries about the minor's immunization status and medication allergies.

This regulation does not require a new intake health screening on minors who are transferred to another juvenile facility within the same detention system. Local policies and procedures for internal clearance for transfer would prevail. The importance of a "health care clearance" prior to transfer within a detention system is discussed in **Section 1432, Health Appraisals/Medical Examinations**. This clearance for transfer is critical, as illnesses acquired in one detention setting might become an epidemic if the individual is transferred to an open camp or dormitory. While a new intake health screening is not required on these internal transfers, it is recommended that the receiving facility have an admission process that includes verification that the necessary health care clearance has been received and an interview with the minor has been conducted to verify and confirm key health related information.

**Section 1431. Intoxicated and Substance Abusing Minors.**

**(a) The responsible physician, in cooperation with the health administrator and the facility administrator, shall develop written policy and procedures that address the identification and management of alcohol and other drug intoxication in accordance with Section 1430.**

**(b) Policy and procedures shall address:**

**(1) designated housing, including use of any protective environment for placement of intoxicated minors;**

**(2) symptoms or known history of ingestion that should prompt immediate referral for medical evaluation and treatment;**

**(3) determining when the minor is no longer considered intoxicated and documenting when the monitoring requirements of this regulation are discontinued;**

**(4) medical responses to minors experiencing intoxication or withdrawal reactions;**

**(5) management of pregnant minors who use alcohol or other drugs;**

**(6) initiation of substance abuse counseling during confinement and referral procedures for continuation upon release to the community consistent with Section 1413 and Section 1355; and,**

**(6) coordination with mental health services in cases of substance abusing minors with known or suspected mental illness.**

**(c) A medical clearance shall be obtained prior to booking any minor who displays outward signs of intoxication or is known or suspected to have ingested any substance that could result in a medical emergency. Supervision of intoxicated minors who are cleared to be booked into a facility shall include monitoring by personal observation no less than once every 15 minutes until resolution of the intoxicated state. These observations shall be documented, with actual time of occurrence recorded. Medical staff, or child supervision staff operating pursuant to medical protocols, shall conduct a medical evaluation for all minors whose intoxicated behavior persists beyond six hours from the time of admission.**

**Guideline:** This regulation applies to all juvenile facilities to varying degrees, depending upon whether minors are booked from the street or transferred from other facilities, and how long they are detained. It establishes requirements related to intoxication and substance abuse management ranging from medical clearance and observation of intoxicated juveniles, to subsequent treatment planning and educational considerations. In the majority of facilities, procedures for the identification and management of substance abusing minors will be established by the responsible physician. In the case of temporary holding and lockup facilities that hold juveniles, the facility administrator will most likely develop these policies.

Juveniles who are arrested while intoxicated are at risk for serious medical consequences, including death. Examples include acute alcohol poisoning, seizures and cardiac complications from cocaine, markedly disordered behavior related to amphetamines or hallucinogenic drugs, and others. The regulation requires that a medical clearance be obtained prior to acceptance into a facility whenever the minor displays outward signs of intoxication or is known or suspected to have ingested any substance that could result in a medical emergency. Important examples of the latter include a history of sequestration of a balloon containing drugs in a body cavity, or juveniles who may have ingested large quantities of drugs immediately prior to arrest in order to eliminate evidence. These minors may initially appear normal, but their condition can rapidly deteriorate.

The determination of the level of intoxication and other substance ingestion concerns will need to be made at the time of the initial intake screening or by the arresting officer before bringing the minor to a police or probation facility. Law enforcement officers have wide and substantial experience recognizing the symptoms of intoxication and are expected to differentiate between a minor who is at risk and needs this medical clearance, and one who has ingested a small amount of an intoxicant. Clearly, minors who are intoxicated to the extent that they are unable to care for themselves would need a medical clearance; however, other minors who have not reached this level, may also require a clearance. Consideration must be given to the length of time since they were known or suspected to have ingested the substance.

When in doubt, the officer should obtain a clearance, particularly if the minor is being transported to a facility without medical staff available on-site. The minor's presenting

symptoms, not the amount of alcohol consumption, should guide the decision for a clearance. Examples of symptoms pointing to a medical clearance include, but are not limited to:

1. drowsiness and/or confusion;
2. body tremors or shakes;
3. a described a history of diabetes or has an ID indicating diabetes;
4. apparent injuries;
5. the minor does not know who or where he/she is and/or the date, time;
6. eyes involuntarily shift back and forth rapidly (horizontal gaze nystagmus);
7. eyes are bloodshot, watery or glassy;
8. poor coordination, staggering and/or swaying;
9. belligerent/combative and/or other self-destructive behaviors are observed;
10. speech is incoherent or slurred;
11. strong odor of alcohol or other intoxicant;
12. vomiting; and/or,
13. breathing/respiration is altered.

A medical clearance will most likely be obtained through a local hospital emergency department. While some emergency departments may choose to observe these minors until they are no longer intoxicated, more often than not they will discharge them to the juvenile facility once they have been examined. When this occurs, a written medical clearance is essential for liability protection of the facility, even though it should be recognized that medical clearance is not an absolute guarantee that problems will not occur. Medical facilities that provide clearance examinations should be familiar with the extent of on-site health services at the juvenile facility in order to best determine when intoxicated minors can be safely monitored there.

Once accepted into the facility, a safe setting for the minor to recover under observation must be determined. Juvenile facilities will vary with respect to use of regular housing rooms versus specially designed "safe" rooms that provide varying types of safeguards and ease of observation. Adult facilities (i.e., lockups) are required to hold minors in a "sobering cell" if, after getting the medical clearance, their level of intoxication is still at level where they are a danger to themselves or others due to their state of intoxication. Policy and procedures must designate the housing options for these minors, including any protective locations for observation. Documented personal observation by staff must be conducted at least every fifteen (15) minutes. Many facilities opt for more frequent observation, especially during the first few hours. When it is clear that recovery is progressing, the intensity of observation may relax slightly, but should remain at fifteen-minute intervals until the minor is determined to no longer be intoxicated. Regardless of whether health care, child supervision staff conduct the checks, the responsible physician must identify the signs and symptoms that should prompt immediate referral for medical care. In lockups, designated staff who are responsible for the jail would observe the minor and the policies would be established by the administrator. Although camera monitoring may be a useful adjunct, it cannot be used as a substitute for direct observation, through which ease of breathing, level of consciousness, and other critically important criteria can be assessed.

Policy and procedures also need to provide guidance to staff in determining when a minor has recovered from the intoxicated state sufficiently to be removed from this special observation status and placed in regular housing. If a minor remains intoxicated after six hours from the time of admission, a medical evaluation must be done. On-site medical staff can do this evaluation. Child supervision staff can be trained in the use of a protocol developed by the responsible physician to distinguish minors who "just need a little more time" from those whose recovery appears abnormal and warrants more formal medical examination.

Policy and procedures must address when and how medical referral and treatment will be rendered to minors whose state of intoxication or withdrawal requires more than observation. Examples include symptomatic heroin withdrawal, with special consideration if this should occur in a pregnant minor. Additionally, amphetamine-induced psychosis, stimulant drug intoxication with neurologic or cardiovascular complications, and alcohol withdrawal syndrome warrant more medical intervention than observation alone.

Once a minor in a juvenile facility has progressed beyond the immediate circumstances surrounding intoxication, consideration needs to be given to addressing the broader issues of substance abuse and related needs. **Sections 1413, Individualized Treatment Plans, 1415, Health Education,** and **1355, Assessment and Plan** relate to these concerns. All substance-abusing minors should be offered substance abuse counseling, which ideally would be initiated within the facility with arrangements for continuation after release. Those who are known or suspected to suffer from mental health disorders have special treatment needs that should be coordinated with mental health staff. Minors who are pregnant, or at high risk of becoming pregnant, would also benefit from substance abuse education and may, in some cases, require specific medical treatment.

**Section 1432. Health Appraisals/Medical Examinations.**

**The health administrator/responsible physician, in cooperation with the facility administrator for each juvenile hall, shall develop written policy and procedures for a health appraisal/medical examination of minors and for the timely identification of conditions necessary to safeguard the health of the minor.**

**(a) The health appraisal/medical examination shall be completed within 96 hours of admission to the facility and result in a compilation of identified problems to be considered in classification, treatment, and the multi-disciplinary management of the minor while in custody and in pre-release planning. It shall be conducted in a location that protects the privacy of the minor and conducted by a physician, or other licensed or certified health professional working within his/her scope of practice and under the direction of a physician.**

**(1) At a minimum, the health evaluation shall include a health history, examination, laboratory and diagnostic testing, and necessary immunizations as outlined below:**

**(A) The health history includes: Review of the intake health screening, history of illnesses, operations, injuries, medications, allergies,**

**immunizations, systems review, exposure to communicable diseases, family health history, habits (e.g., tobacco, alcohol and other drugs), developmental history (e.g., school, home, and peer relations), sexual activity, contraceptive methods, reproductive history, physical and sexual abuse, neglect, history of mental illness, self-injury, and suicidal ideation.**

**(B) The examination includes: Temperature, height, weight, pulse, blood pressure, appearance, gait, head and neck, a preliminary dental and visual acuity screening, gross hearing test, lymph nodes, chest and cardiovascular, breasts, abdomen, genital (pelvic and rectal examination, with consent, if clinically indicated), musculoskeletal, neurologic.**

**(C) Laboratory and diagnostic testing includes: Tuberculosis testing, together with pap smears and testing for sexually transmitted diseases for sexually active minors. Additional testing should be available as clinically indicated, including pregnancy testing, urinalysis, hemoglobin or hematocrit.**

**(D) Immunizations shall be verified and, within two weeks of the health appraisal/medical examination, a program shall be started to bring the minor's immunizations up-to-date in accordance with current public health guidelines.**

**(2) The health examination may be modified by the responsible physician, for minors admitted with an adequate examination done within the last 12 months, provided there is reason to believe that no substantial change would be expected since the last full evaluation. When this occurs, health care staff shall review the intake health screening form and conduct a face-to-face interview with the minor.**

**(b) For adjudicated minors who are confined in any juvenile facility for successive stays, each of which totals less than 96 hours, the responsible physician shall establish a policy for a medical evaluation and clearance. If this evaluation and clearance cannot be completed at the facility during the initial stay, it shall be completed prior to acceptance at the facility. This evaluation and clearance shall include screening for tuberculosis.**

**(c) For minors who are transferred to jails and juvenile facilities outside their detention system, the health administrator, in cooperation with the facility administrator, shall develop policy and procedures to assure that a health appraisal/medical examination:**

**(1) is received from the sending facility at or prior to the time of transfer;**

**(2) is reviewed by designated health care staff at the receiving facility; and,**

**(3) absent a previous appraisal/examination or receipt of the record, a health appraisal/medical examination, as outlined in this regulation, is completed on the minor within 96 hours of admission.**

**(d) The responsible physician shall develop policy and procedures to assure that minors who are transferred among juvenile facilities within the same detention system, receive a written health care clearance. The health appraisal/medical examination shall be reviewed and updated prior to transfer and forwarded to facilities that have licensed on-site health care staff.**

**Guideline:** This regulation applies to all juvenile facilities, as well as to jails that hold minors. Lockup facilities are excluded, as they do not detain minors long enough for the requirements to apply. In the case of special purpose juvenile halls, only part of the regulation applies to juveniles who are committed to serve repeated successive periods of time, each of which totals less than 96 hours.

The regulation requires the health administrator/responsible physician to develop policy and procedures for a routine health appraisal/medical evaluation of minors to be conducted within 96 hours of admission to the facility. The facility must maintain good intake health screening procedures **(Section 1430, Intake Health Screening)** and make provision for minors to request health care attention at any time **(Section 1433, Request for Health Care Services)**. The regulation allows flexibility in conducting health appraisals/examinations of minors who already have had one completed one within the last twelve months. In those instances the minimum requirement is a face-to-face interview with licensed health care staff. Requirements for a medical clearance are imposed on juveniles who are committed to multiple, successive brief stays (e.g., "weekenders"). The regulation also specifies that receiving a copy of the health appraisal on a minor transferred from another jurisdiction can satisfy the requirement, but a full health appraisal is required within 96 hours if the information is not received. Finally, for intra-jurisdictional transfers, a non-confidential "health care clearance" must be completed and forwarded to the receiving facility.

The health appraisal/medical examination is a systematic approach to evaluation of the health care needs of minors, regardless of whether they have requested attention. The regulation calls for completion of the evaluation within 96 hours of arrival at the facility. The time frame is <u>not</u> modified due to weekends, holidays, or other factors.

Facilities should not depend upon the health appraisal to identify conditions that require immediate or early attention. The intake health screening, prompt response to requests for care, and careful ongoing observation by child supervision staff are essential to accomplishing necessary treatment within appropriate time frames. The need for immediate treatment may be recognized even before the minor is accepted for booking (i.e., in the "pre-booking" phase), and referral should not be delayed **(Section 1430, Intake Health Screening)**.

The health appraisal/medical examination addresses health issues that become increasingly important as the minor's period of detention continues. It is intended to detect illness that is of significance to the institution or individual, yet may have symptoms that would otherwise be disregarded (e.g., tuberculosis, some sexually transmitted diseases, etc.). The health appraisal should take a "holistic" approach that includes dental and mental health concerns. Because immunization of the juvenile population is a significant factor in maintaining the health of both minors and persons with whom they are in contact, updating of vaccines is an important part of the process. Juveniles are also at significant risk for sexually transmitted diseases, such as chlamydia. It is recommended that you consult with your local health officer regarding current recommendations for screening. Screening while in custody will benefit not only the individual, but also the community with whom they will interact after release.

In general, juvenile facilities serve as important "catchment areas" where interventions of significant public health importance occur. Approaches should consider the special needs of this adolescent population, such as the often understated effects of lead exposure that can result from both environmental factors and retained lead from gunshot wounds. Conditions that affect the functional status of the minor deserve specific emphasis, as hearing and visual acuity disorders can greatly impact school performance and adjustment in society.

The outcome of the health appraisal/medical evaluation should be a compilation of health issues of significance to the minor[4] which provides the basis for making recommendations to child supervision staff regarding classification issues and any limitations that may affect current and future programming **(Section 1355, Assessment and Plan, and Section 1413, Individualized Treatment Plans)**. In addition, the health appraisal/medical examination is the starting point for updating immunization status, planning other medical testing, and preventive health measures (e.g. health education, family planning, etc.). This approach benefits the juvenile facility and community as a whole, in addition to assisting in an effective, comprehensive approach to managing the individual minor.

The health appraisal/examination must be conducted by a physician or qualified designee who is working within the appropriate scope of practice and under the direction of a physician. This could be a physician's assistant, nurse practitioner or registered nurse with additional training in physical assessment.

The health appraisal/medical examination must be conducted in privacy, limited only by significant security considerations. At a minimum, the following must be included:

1. Health history, including review of the intake health screening, history of illnesses, operations, injuries, medications, allergies, immunizations, systems review, exposure to communicable diseases, family health history, habits (e.g., tobacco, alcohol and other drugs), developmental history (e.g., school, home, and peer relations), sexual activity, contraceptive methods, reproductive history, physical and sexual abuse, neglect, history of mental illness, self-injury and suicidal ideation.

2. Physical examination, including temperature, height, weight, pulse, blood pressure, appearance, gait, head and neck, a preliminary dental and visual acuity screening, gross hearing test, lymph nodes, chest and cardiovascular, breasts, abdomen, genital (pelvic and rectal examination with verbal consent, if clinically indicated), musculoskeletal, and neurologic.

3. Laboratory and diagnostic testing including, tuberculosis testing, pap smears and testing for sexually transmitted diseases for sexually active minors. Other testing should be provided as clinically indicated, including pregnancy testing, urinalysis, hemoglobin or hematocrit.

[4]In the Problem Oriented Medical Record, this would comprise the "Problem List" (Section 1406, Health Care Records).

4. Immunizations shall be verified and, within two weeks of the health appraisal/medical examination, a program shall be started to bring the minor's immunizations up-to-date in accordance with current public health guidelines.

It is recognized that accurate verification of immunization status can often be difficult. While schools may be able to assist with information, their records may not be complete. Whenever possible, information should be obtained from parents. A two-week time frame is allowed for establishing a plan to update immunizations in order to avoid the "over-immunization" that occurs when vaccines are arbitrarily given when a history cannot be obtained immediately. Consent issues need to be considered when immunizing minors. Requirements for provision of a Vaccine Information Pamphlet (VIP) apply when parents give consent for immunization; the requirement does not apply when the court supplies consent. Potential contraindications to immunization, such as pregnancy and immunosuppression, should not be overlooked.

A dental screen is an essential part of the health appraisal. While this need not be conducted by a dental professional, it should include a general inspection of the oral cavity with notation of broken teeth, cavities, abnormal conditions of the gums, and dental prostheses or orthodontics, with referral to an appropriate dental professional as needed. Because of the importance of dental health to self-image and overall well-being emphasis should be given to potentially correctable conditions.

The regulation allows the responsible physician to modify the extent of the health appraisal for minors who have had one completed within the past 12 months. This can be done as long as there is no reason to believe that a substantial change has occurred since that time. However, it is still necessary for health care staff to conduct a face-to-face interview with the minor and document the results. Emphasis should be given to any new symptomatology, known or suspected exposure to communicable diseases, new medications or development of drug allergies and the possibility of pregnancy in females.

In addition, a health appraisal/examination from another jurisdiction can be accepted if a copy is received when a juvenile transfers from another facility; however, this does not preclude facilities from performing their own assessment if they choose to do so. Similarly, a copy of the health appraisal/medical exam must either accompany minors who are transferred to jail facilities or the jail must conduct its own evaluation within 96 hours.

As is the case in all non-emergency health care interventions, minors have the right to refuse a health appraisal/medical examination. It is recommended that any consequences resulting from a refusal be based on specific rationale. For instance, a minor with a chronic cough who refuses tuberculosis screening may be isolated from others, whereas isolation of an apparently healthy individual may be more difficult to justify. Disciplinary procedures should not be instituted as the result of refusal of health screening.

While there is no specific requirement for periodically updating health appraisal/medical examinations, facilities should consider policy that takes into account the significant physical changes experienced by the adolescent age group. It may be beneficial to develop procedures for periodic re-evaluation of minors whose detention is unusually prolonged.

In some instances, minors are required to report to juvenile facilities for multiple, successive stays of less than 96 hours each (e.g., "weekenders"). Although these minors are not subject to the health appraisal requirement as detailed above, it is necessary for the responsible physician to define a policy for medical evaluation and clearance. If desired, on-site health care staff can provide the assessment if it can be accomplished during the initial stay. However, many smaller facilities will not have on-site health care staff, or they may not be available during the initial stay. The option exists to require completion of the examination at parental expense prior to admission. The responsible physician must specify the details of the clearance examination, with emphasis on those aspects that are most relevant to facility safety, such as tuberculosis testing and necessary continuation of medications. There is no provision for allowing parents or guardians to sign "waivers of responsibility" that bypass the clearance process, as these waivers would increase medical risks to the minor and liability to facility.

When minors transfer to facilities within the same jurisdiction, the health appraisal/medical examination should be updated as needed to assure that it is current, and a copy forwarded to health care staff at the receiving institution. Facilities without licensed health care staff on-site, cannot legally maintain these records; in these instances, a health appraisal/medical examination is not sent **(Section 1406, Health Care Records)**. In the case of all intra-jurisdictional transfers, a non-confidential "health care clearance" form is required to verify for supervision staff that the minor has been medically cleared for transfer to the facility. The "health care clearance" represents a simple statement that there are no health conditions that preclude the minor from being housed at the facility, and additionally specifies any unusual needs of which supervision staff should be aware.

When minors transfer to facilities outside the county's juvenile detention system, a copy of the health appraisal/medical examination should be forwarded for review by licensed health care staff at the receiving facility. If a health appraisal is not sent, the receiving facility must perform one within 96 hours of admission, just as it would in the case of any newly booked minor. This approach also applies to jails, whether or not the juvenile came from their own or another county. Even if the copy of a health appraisal has been received, it should be carefully reviewed to assure that it is current. It is recommended that the minor be interviewed to clarify any concerns about identified conditions or recent developments in health status.

## Section 1433. Requests for Health Care Services.

**The health administrator, in cooperation with the facility administrator, shall develop policy and procedures to establish a daily routine for minors to convey requests for emergency and non-emergency health care services.**

**(a) There shall be opportunities for both written and verbal communications, including provision for minors who have language or literacy barriers.**

**(b) Child supervision staff shall relay requests from the minor, initiate referrals when a need for health care services is observed, and advocate for the minor when the need for services appears to be urgent.**

**(c) Designated staff shall inquire and make observations regarding the health of each minor on a daily basis and in the event of possible injury.**

**(d) There shall be opportunities available on a twenty-four hour per day basis for minors and staff to communicate the need for emergency health care services.**

**(e) Provision shall be made for any minor requesting health care attention, or observed to be in need of health care, to be given that attention by licensed or certified health care personnel.**

**(f) All health care requests shall be documented and maintained.**

**Guideline:** This regulation applies to all juvenile facilities and requires designated staff to inquire and make observations regarding the health of each minor on a daily basis. Opportunity must be provided for the minor to request clinic visits and for staff to request health services on behalf of the minor, based on their observation that it is needed. There must be a system to maintain documentation of verbal and written health care requests, regardless of whether they originate from the minor or from staff. Both emergency and non-emergency requests must be responded to in a timely manner. The guiding principle should be that any minor requesting or needing medical attention shall receive such attention as soon as is reasonable and possible.

Local policy will determine which designated staff makes daily inquiry and observation of health care needs as specified by this regulation. Child supervision or health care staff may do it, but there should be an established routine, with provision for additional requests whenever needed. Minors need to be informed of these procedures during their orientation, in a manner, language and vocabulary that is understood by them **(Section 1353, Orientation).** Consideration should be given to posting signs in appropriate languages at key locations in the facility.

When child supervision personnel conduct the inquiry and make observations concerning health care needs, the intent is not to decide who needs medical attention. Rather they are to appropriately refer everyone making a request for medical/mental health attention. Sometimes supervision staff makes a judgment about the urgency of referral, but they must be careful to avoid making diagnostic decisions about the minor's condition. It is up to health personnel to determine the kind of attention a minor requires. That attention may include: review of the request slip; review of the minor's file; referral; and treatment. Requests from minors do not mandate a level of care or type of service, but should be viewed as a means of getting the attention of health care personnel who will then determine what intervention best fits the situation.

It is important for supervision staff to maintain sensitivity to minors who need mental health attention and may be unwilling or unable to identify themselves. Mental health staff can support this staff development by training and outreach when making mental health rounds or when

conducting similar activities. Minors with "internalizing" mental disorders cannot be counted on to express concerns or speak up at sick call. Staff observation skills and referrals are particularly critical if these minors are to get the attention they need.

Local policy, taking into account the size and type of facility, will determine how requests for health care should be documented and maintained. In some facilities, it could be appropriate to put "sick call" slips in the health care file and note verbal requests there as well. Other facilities, particularly those without on-site health care staff, may consider documentation in a log, together with noting the follow-up provided. Procedures need to take into account that not all requests will be in writing.

Although the recognition of illness is an extremely important function, an overall philosophy of "wellness" should be emphasized. Approaches that reward minors who take on unnecessary roles of illness, or policies that allow medical conditions to unnecessarily excuse or serve as a basis for non-participation are discouraged.

**Section 1434. Consent for Health Care.**

**The health administrator, in cooperation with the facility administrator, shall establish written policy and procedures to obtain informed consent for health care examinations and treatment.**

**(a) All examinations, treatments, and procedures requiring verbal or written informed consent in the community also require that consent for confined minors.**

**(b) There shall be provision for obtaining parental consent and obtaining authorization for health care services from the court when there is no parent/guardian or other person standing in loco parentis.**

**(c) Policy and procedures shall be consistent with applicable statutes in those instances where the minor's consent for testing or treatment is sufficient or specifically required.**

**(d) Conservators can provide consent only within limits of their court authorization.**

**Minors may refuse, verbally or in writing, non-emergency medical and mental health care.**

**Guideline:** All juvenile facilities must establish policy and procedures to obtain consent to examine and treat minors. This regulation identifies the health administrator as having the lead in developing written policy and procedures for consent, in cooperation with the facility administrator. This lead role for the health administrator is appropriate due to the complexity of consent statutes for minors and the importance for health services; however, local procedures will determine responsibilities of probation and health care staff with respect to actually obtaining consent. While probation may have greater ability to carry out the logistics of obtaining general consent, it is still up to the health care professionals to assure that the consent obtained is adequate for the proposed treatment.

While this may appear to be a straightforward task, it is complicated by a bewildering array of statutes concerning the varying authority to give consent in certain circumstances. For this reason, it is strongly advised that administrators obtain legal review of procedures and legal advice in any specific instances that are not clear. Further, these statutes are subject to change over time, so policies should be regularly reviewed to assure that they are consistent with current law. Statutes that are relevant to consent include **Health and Safety Code, Section 199.27**, together with **Family Code, Sections 7050, 6922, 6924** through **6929** and **6911**.

While emergency, life-saving treatment can always be rendered without specific consent, it is also true that any minor may choose to refuse any non-emergency treatment, regardless of who gave consent in the first place. Only a court order can override a minor's desire to refuse treatment.

The initial form of consent that a facility should pursue is one that would allow general, routine health care services. It is highly desirable that parental or guardian consent be obtained, whenever possible. This allows for the appropriate involvement of parents, as well as an opportunity to gain additional important information about the minor, such as a history of medication allergies. Only when attempts to obtain parental consent are ineffective should the court be utilized as a substitute.

Caution should be exercised in adopting any policy that utilizes a "blanket consent" from the parent or guardian or the court for all types of health care, as it is not likely to be valid in some circumstances. Whenever treatment goes beyond a routine level of care, such as in the case of invasive procedures, surgery, or initiation of psychotropic medications, specific informed consent is required. This involves a full discussion of the recommended treatment, its risks and benefits, alternatives, and consequences of refusing the treatment. In general, this would require consent of a parent, guardian, or court, if no parent or guardian is involved. In the event that a conservator has been appointed for the minor, the courts will specify the extent to which the conservator may or may not provide consent to health care.

In certain specified situations, minors have the ability to consent to care without parental involvement. These provisions would apply equally within juvenile facilities as in the open community. Examples include: examinations and treatment for pregnancy (with some restrictions applicable to requests for therapeutic abortion services); family planning; treatment for communicable diseases reportable to the local health officer including sexually transmitted diseases; mental health treatment (except for psychotropic medications); and substance abuse treatment.

In the case of immunizations, consent from the parent or court is generally required. When parental consent is involved, it is necessary to provide them with vaccine information consistent with requirements of the Vaccine Injury Reform Act. Minors may consent to receipt of Hepatitis B vaccine if they are determined to be at risk for sexual transmission of that infection.

**Section 1435. Dental Care.**

**The health administrator, in cooperation with the facility administrator, shall develop written policy and procedures to require that dental treatment be provided to minors as necessary to respond to acute conditions and to avert adverse effects on the minor's health. Such treatment shall not be limited to extractions.**

This regulation applies to all juvenile facilities, though the extent of services will, at times, depend upon the anticipated length of stay. It requires that the health administrator develop policies that result in the provision of dental care, not limited to extractions, in order to treat acute and other conditions that, if left untreated, would have an adverse effect on the health of the minor.

Initial screening for dental pathology involves a basic inspection of the oral cavity as described under **Section 1432, Health Appraisals/Medical Examinations**. It is expected that arrangements for referral would be made for conditions requiring treatment during the period of confinement.

Determining the need for referral involves exercising judgment that balances the acuity and progressive nature of the condition with the anticipated length of stay in the juvenile facility. Longstanding and stable conditions do not generally demand immediate intervention. On the other hand, a tooth that is severely fractured while the minor is in custody may require emergency intervention to prevent irreversible loss. Intermediate situations may be less clear. In any case, it is important that facilities not adopt the stance of limiting treatment to extractions. The importance of dental health to self-esteem and even future employability is of particular significance to the juvenile population and needs to be taken into account in treatment decisions. While there is no expectation of extensive restorative treatment, decisions on "gray area" situations should err on the side of preserving salvageable teeth.

Child supervision and on-site health care staff should be trained in the recognition of dental emergencies, dental first aid procedures, and the time frame within which interventions are required. This is particularly important in situations of injuries to the mouth and face.

Dental services may be provided either on-site or in community-based offices. While the latter is most common, on-site dental offices are justifiable in larger facilities, and portable dental equipment makes on-site dental care realistic for many medium-sized facilities.

While this regulation does not call specifically for professional dental hygiene services and preventive maintenance examinations, consideration should be given to provision of such treatment to minors with unusually long periods of confinement in order to prevent deterioration of dental health over the extended time frame. Instruction in dental hygiene is an important element of health education and can be considered within the context of **Section 1415, Health Education.**

**Section 1436. Prostheses and Orthopedic Devices.**

**(a) The health administrator, in cooperation with the facility administrator and the responsible physician shall develop written policy and procedures regarding the provision, retention and removal of medical and dental prostheses, including eyeglasses and hearing aids.**

**(b) Prostheses shall be provided when the health of the minor would otherwise be adversely affected, as determined by the responsible physician.**

**(c) Procedures for retention and removal of prostheses shall comply with the requirements of Penal Code Section 2656.**

**Guideline:** This regulation applies to jails holding juveniles as well as to all juvenile facilities. It requires that prostheses be provided if the treating physician determines that the health of the minor would otherwise be adversely affected. It also requires that **Penal Code, Section 2656,** be followed with respect to retention and removal of prostheses. Prostheses may not be removed unless there is probable cause to believe that they present risk of bodily harm to someone in the facility or threaten facility security. They must be returned to the minor when the risk no longer exists.

Prostheses are artificial devices to replace missing body parts or to compensate for defective bodily function. Prostheses are distinguished from slings, crutches, or other similar assistive devices. Care should be taken so as not to place minors in a situation where prostheses may be used as weapons.

This regulation includes dental prostheses, eyeglasses and hearing aids among the types of prostheses that must be provided to the minor if prescribed by the treating physician. It is anticipated that policies related to provision of prostheses would parallel what would be done under a similar circumstance in the community and also consider the minor's length of stay in a facility. Minors who are expected to remain in the facility for several months may reasonably have different requirements than a minor who will be released back to the community in a matter of days.

Inappropriate removal of some devices (e.g., artificial limbs, etc.) can result in injury to the minor. **Penal Code, Section 2656,** relates specifically to adult inmates. While there is no comparable statute specifically for juveniles, those requirements are incorporated by regulation (with clarifying language concerning dental prostheses, eyeglasses and hearing aids) because the same principles are applicable to juveniles and likely to be upheld in any challenge. The law is very specific; it says if the facility manager:

> "…has probable cause to believe possession of such orthopedic or prosthetic appliance constitutes an immediate risk of bodily harm to any person in the facility or threatens the security of the facility, such appliance may be removed.
>
> If such appliance is removed, the prisoner shall be deprived of such appliance only during such time as the facts which constitute probable cause for its removal

continue to exist; if such facts cease to exist, then the person in charge of the facility shall return such appliance to the prisoner.

When such appliance is removed, the prisoner shall be examined by a physician within 24 hours after such removal."

Facilities cannot deprive minors of these devices without a security or safety reason. Policies and procedures should discuss the security parameters that might constitute cause for withholding such an appliance, for how long, and with what recourse. How individuals with artificial limbs and other prostheses are to be accommodated in the facility should also be addressed.

**Section 1437. Mental Health Services and Transfer to a Treatment Facility.**

**The health administrator/responsible physician, in cooperation with the mental health director and the facility administrator, shall establish policies and procedures to provide mental health services. These services shall include, but not be limited to:**

**(a) screening for mental health problems at intake;**

**(b) crisis intervention and the management of acute psychiatric episodes;**

**(c) stabilization of persons with mental disorders and the prevention of psychiatric deterioration in the facility setting;**

**(d) elective therapy services and preventive treatment where resources permit;**

**(e) medication support services;**

**(f) provision for timely referral, transportation, and admission to licensed mental health facilities, and follow-up for minors whose psychiatric needs exceed the treatment capability of the facility; and,**

**(g) assurance that any minor who displays significant symptoms of severe depression, suicidal ideation, irrational, violent or self destructive behaviors, or who is receiving psychotropic medication shall be provided a mental status assessment by a licensed mental health clinician, psychologist, or psychiatrist.**

**Mentally disordered minors who appear to be a danger to themselves or others, or to be gravely disabled, shall be evaluated pursuant to Penal Code Section 4011.6 or Welfare and Institutions Code Section 6551. Absent an emergency, unless the juvenile facility has been designated as a Lanterman-Petris-Short (LPS) facility, and minors meet the criteria for involuntary commitment under the LPS Act in Welfare and Institutions Code Section 5000 et seq., all services shall be provided on a voluntary basis. Voluntary mental health**

**admissions may be sought pursuant to Penal Code Section 4011.8 or Welfare and Institutions Code Section 6552.**

**Guideline:** Every juvenile facility must define and provide for essential mental health services. The range and extent of services will depend on the type of facility and level of need of the minors it holds. At a minimum, facilities must have a method to screen for mental disorders upon intake and provide for both crisis intervention and stabilization of acute psychiatric episodes. They must also intervene as necessary to prevent avoidable deterioration of the minor's mental health while in custody, provide medication support services and provide a method for transferring minors to a licensed facility when a higher level of care is needed. Where resources permit, access to counseling on an elective basis and preventive mental health services are highly desirable.

A mental health program may include a variety of licensed professionals, including physicians, psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, registered nurse specialists, and psychiatric technicians. In general, where there is a team consisting of a variety of professionals, a physician would be the designated "leader," especially where a formal psychiatric diagnosis and psychotropic medications are involved.

Procedures should address how to provide for continuation of psychotropic medications that were prescribed in the community prior to and booking into a juvenile facility. Consideration needs to be given to verifying parental consent and arranging for psychiatric follow-up.

There is a high prevalence of psychiatric illness and situational stress in minors who are confined in juvenile facilities. Acting out and other delinquent behavior may be a sign of a mental disorder and need for treatment. It is vital that minors exhibiting suicidal, other self-destructive behavior or who appear to be mentally disordered based on irrational or bizarre behavior, be promptly and adequately evaluated by a licensed mental health professional. The speed with which such an evaluation is conducted should be appropriate to the apparent acuity of the problem. Markedly disordered behavior should be treated as an emergency in most cases.

When necessary, a minor can be transferred from a juvenile facility to a licensed inpatient mental health facility on an involuntary basis utilizing the provisions of **Penal Code, Section 4011.6,** or **Welfare and Institutions Code, Section 6551**. Under both of these codes, an evaluation utilizing the "5150" criteria of the **Welfare and Institutions Code** is initiated. There are also some circumstances in which a transfer can be accomplished on a voluntary basis utilizing **Penal Code, Section 4011.8,** or **Welfare and Institutions Code, Section 6552**. In either case, it is important to establish arrangements whereby transfer to a licensed level of treatment is possible whenever the treatment capabilities at the juvenile facility are exceeded.

With dwindling community resources, responding to seriously mentally disordered persons is an increasingly acute problem for detention administrators at both the juvenile and adult level. Inpatient mental health beds are at a premium and often not readily accessible to persons who are already held in locked facilities. However, it is important that juvenile facilities do not acquiesce to pressures to become substitute inpatient facilities when they are not licensed, equipped or trained to do so. Furthermore, absent an emergency, psychotropic medications may not be given

to minors in a juvenile facility on an involuntary basis. When consent for medication cannot be obtained from both the parent and the minor, transfer to a licensed facility is a necessary prerequisite to treatment. Administrators must work proactively and cooperatively with mental health officials and others in the community to improve availability of mental health services for minors in lieu of having their detention facilities expand as the mental health service provider of last resort.

**Section 1438. Pharmaceutical Management.**

**For all juvenile facilities, the health administrator, in consultation with a pharmacist and in cooperation with the facility administrator, shall develop written policy, establish procedures, and provide space and accessories for the secure storage, controlled administration, and disposal of all legally obtained drugs.**

**(a) Such policies, procedures, space and accessories shall include, but not be limited to, the following:**

- **(1) securely lockable cabinets, closets, and refrigeration units;**
- **(2) a means for the positive identification of the recipient of the prescribed medication;**
- **(3) administration/delivery of medicines to minors as prescribed;**
- **(4) confirmation that the recipient has ingested the medication;**
- **(5) documenting that prescribed medications have or have not been administered, by whom, and if not, for what reason;**
- **(6) prohibition of the delivery of medication from one minor to another;**
- **(7) limitation to the length of time medication may be administered without further medical evaluation;**
- **(7) the length of time allowable for a physician's signature on verbal orders; and,**
- **(8) a written report shall be prepared by a pharmacist, no less than annually, on the status of pharmacy services in the institution. The pharmacist shall provide the report to the health authority and the facility administrator.**

**(b) Consistent with pharmacy laws and regulations, the health administrator shall establish written protocols that limit the following functions to being performed by the identified personnel:**

- **(1) Procurement shall be done only by a physician, dentist, pharmacist, or other persons authorized by law.**
- **(2) Storage of medications shall assure that stock supplies of legend medications shall only be accessed by licensed health personnel. Supplies of legend medications that have been properly dispensed and supplies of over-the-counter medications may be accessed by both licensed and non-licensed personnel.**
- **(3) Repackaging shall only be done by a physician, dentist, pharmacist, or other persons authorized by law.**
- **(4) Preparation of labels can be done by a physician, dentist, pharmacist or other personnel, both licensed and non-licensed, provided the label is**

**checked and affixed to the medication container by the physician, dentist, or pharmacist before administration or delivery to the minor. Labels shall be prepared in accordance with Section 4047.5 of the Business and Professions Code.**

**(5) Dispensing shall only be done by a physician, dentist, pharmacist, or other person authorized by law.**

**(6) Administration of medication shall only be done by licensed health personnel who are authorized to administer medication and acting on the order of a prescriber.**

**(7) Licensed and non-licensed personnel may deliver medication acting on the order of a prescriber.**

**(8) Disposal of legend medication shall be done in accordance with pharmacy laws and regulations and requires any combination of two of the following classifications: physician, dentist, pharmacist, or registered nurse. Controlled substances shall be disposed of in accordance with Drug Enforcement Administration disposal procedures.**

**(9) The responsible physician shall establish policies and procedures for managing and providing over -the-counter medications to minors.**

**Guideline:** This regulation reflects the thinking of a special task force in the late 1980's. In response to litigation, Senator Presley authored legislation submitted by the State Pharmacy Association regarding the management of medications in detention and corrections settings. The bill directed that the Board of Pharmacy, the State Pharmacy Association, the California Youth Authority, the State Board of Corrections, and the State Department of Health, the California Nurses Association, the California Medical Association, and the State Department of Corrections to study the issue of pharmaceutical management. The language in this juvenile regulation parallels that which was developed by the initial pharmacy task force, with the addition of requiring policies and procedures related to over-the-counter (OTC) medications.

In essence, this regulation parallels Board of Pharmacy regulations governing the management of pharmaceuticals in the community related to the ordering, storing, prescribing, dispensing, administration and delivery of drugs in the facility. To the degree that juvenile facilities provide medications, this regulation would apply, all or in part, to all juvenile facilities. As with other regulations, this one calls for written policies and procedures, in this instance, developed by the health administrator and the responsible physician, in consultation with the facility administrator and a pharmacist. Key terms related to this regulation are also addressed in **Section 1302, Definitions.**

The issues related to pharmaceuticals are complex and pose the potential for significant liability. It is important to spell out as clearly as possible how prescription and other medications are to be securely stored and administered, together with disposal methods. Each facility should have procedures that assure compliance with all applicable state and federal laws and regulations regarding acquisition, storage, labeling, packaging, disposal and administration of drugs. Despite the uniqueness of these facilities, all aspects of health care services, including the management of pharmaceuticals, are governed by the same laws and regulations as in the community.

To assure that prescription and nonprescription drugs are managed properly in the facility, it is advisable to hire a pharmacist consultant or, in large facilities, it may be cost effective to hire an on-site pharmacist. The pharmacist or pharmacist consultant can work in conjunction with the health administrator and make recommendations regarding the facility formulary, assure appropriate storage, handling and inventory control, provide for destruction of old medication, provide regular chart reviews on medication utilization and, in larger systems, participate on various committees.

All pharmaceutical supplies are to be kept in a secure area of the facility with access limited by proper key control. A close inventory must be kept of these supplies to ensure that unauthorized use or removal will be promptly discovered. While all medications must be maintained in secure locations and under the appropriate environmental conditions to assure their effectiveness, legend drugs must be kept in securely locked cabinets. Access to medications must be limited by policy. In larger jurisdictions with designated pharmacies, the facility manager may have a key to the pharmacy or drug area for security reasons, but not to the controlled substance storage area.

When stock medications are maintained within a detention facility, there must be a formulary of medications stored in that facility. A formulary serves two major purposes: 1) cost containment is improved by eliminating costly duplication of expensive treatment alternatives; and 2) a reference list of readily available medications is maintained for the treatment staff. The physical isolation of some facilities can make it difficult to obtain medications promptly, so keeping a stock of commonly used medications may improve efficient treatment in a cost effective manner. It is acceptable to administer stock legend (prescription) medications by removing single doses at a time, provided this is done by licensed health care staff; preparation of multi-dose packages of medication from bulk stock can be done only by a physician or pharmacist.

Carefully adhere to procedures for the proper disposal of legally obtained drugs and supplies. Dated medications should be routinely purged from stock after their period of use or expiration dates. Facilities that rely on community pharmacies should work with those pharmacists to develop written policies and procedures for destruction of unused drugs. Consideration should be given to incorporating this responsibility into the facility's contract for pharmaceutical services. In larger systems having in-house pharmacies, an inventory of controlled medications to be destroyed must be developed and signed by two licensed health professionals in accordance with the State Board of Pharmacy regulations. This record must be maintained for three years. Policies and procedures for returning unused medications to the pharmaceutical company may be more advantageous than in-house destruction. Community regulations and statutes in this area may change, and establishing a disposal plan with a licensed pharmacist appears to be the best way to remain current with requirements.

Equipment, such as used needles and syringes, should be disposed of in puncture-resistant containers and discarded according to currently accepted medical waste disposal procedures. Because of increasing awareness of risks for acquiring Hepatitis B and HIV infections through cutaneous injury by blood-contaminated sharp instruments, it is no longer recommended that

contaminated disposable needles be either resheathed or broken prior to disposal. Each county's Division of Environmental Health is a resource to assist in developing policies in this area.

It is crucial that the minor for whom a dose of a particular medication is intended is the one who receives that medication; thus, there must be clear policy, consistently followed, regarding positive identification of recipients of medication. Some systems opt for hospital-type identification wrist bands or photographs on medical records or I.D. cards; these options, while not required, should be seriously considered because, particularly in receiving facilities and facilities with more than a handful of minors, it is impossible to identify individuals by recognition only. Staff should not rely on knowing minors by face.

It is important to distinguish between "dispensing," "administering" and "delivering" medications. Licensed medical staff is not the only personnel who can deliver medications, but they are the only ones who can dispense and administer them.

1. Dispensing medications can be defined as compounding, packaging, preparing, counting, labeling or in any way filling a prescription. Dispensing can only be done by a licensed physician or pharmacist.

2. Administering refers to the act in which a single dose of a prescribed drug is given to the patient from a bulk container of medication. This can only be done by a licensed medical person, one dose at a time, in accordance with law and regulation. Supervision staff cannot administer a dose of prescription medication from a bulk container.

3. Delivery can be done when there is a properly labeled prescription container (i.e., a dated container which includes the name of the individual for whom the drug is prescribed, the name of the medication, dose and instructions for taking the medication, the name of the prescribing physician and expiration dates). Under these circumstances, a single dose at a time can be delivered to the minor according to the written instructions by any licensed nursing personnel or by supervision staff.

Under any of these circumstances, when a minor is given medication, it is important to verify the dose with the prescriber's orders, give the individual dose to the proper minor and promptly record the time, dose and name of the person giving the medication. Some medications require that they be taken with food, typically to prevent digestive upset. Whenever this is the case, the physician's prescription will specify that the medication be taken with food.

Given the realities of the detention setting, it is often difficult to provide medications on an ideal schedule. Some medications must be given more frequently than others and some must be taken on an empty stomach; these and other issues mean health and child supervision staff must have agreed upon written policy and procedure for melding security and control concerns with the medical and mental health needs of minors. Movement of minors, court appearances, and conflicting activities all interfere with scheduled "pill calls." Facilities should consider methods for providing important medications to those individuals attending court, working in areas not routinely accessible to medical staff or embarking on lengthy transports, and it may be helpful

for the prescribing physician to indicate in the medication orders how much leeway is reasonable and safe for a given medication and patient.

Long acting formulations of medications are becoming increasingly available and are attractive for use in detention settings because they are given less frequently and allow for reduced staff involvement. If such long acting formulations are used, it is important to realize that "soaking" medications in water prior to administration for security purposes is likely to affect the absorption pattern, thus interfering with sustained release characteristics of some drug preparations.

Medications brought by or with a minor on admission to a facility are, generally speaking, not advisable to use. However, sometimes the best way to provide needed medication is from the minor or the minor's family. Such medications should not be used unless the prescription is current (dated within the last two weeks or, for chronic medications, within the past three months) and the contents of the container(s) have been examined for positive identification and approved by the facility's responsible physician or designee. For security reasons, it is preferable that no medication from any source other than the facility or system be used; however, this is not always possible in smaller facilities. For larger systems, unusual medications not stocked in the facility pharmacy can be special ordered. Prescription medications brought from outside can be recorded on the minor's property record and stored in a secure area until release. It is appropriate to use medications transferred from other detention facilities if there is a secure method for ensuring that individual minor's prescriptions are not tampered with in transit and that containers are properly labeled.

Procedures for confirming that the recipient has ingested the medication given to him or her are required. Watching a minor take prescription medications is known as "directly observed therapy" (DOT). This regulation requires DOT to ensure that the drugs are ingested. Since nursing staff often cannot get to the locations of work crews, court, etc., there must be policy related to DOT for those minors as well. It is important to the treatment of many illnesses, tuberculosis prime among them, that medications be ingested on a regular schedule and that staff observe the ingestion. Further, ensuring that minors take their medications when administered is an issue related to facility security and the minor's safety. Minors must not be sequestering their prescription medications for later use as currency or for accumulation and ingestion in an overdose. Staff should guard against the opportunity for minors to intimidate others into saving and sharing medications.

The use of liquid formulations may be considered for psychotropic and other controlled medications, as these are more difficult to sequester; however, there are some downsides to liquid formulations. For example, not all drugs are available in liquid form, the bad taste of most liquids or powders could discourage minors from accepting treatment, and the high cost of liquid forms of medications could be prohibitive. Nonetheless, liquid medications solve some ingestion problems that may make the additional cost worthwhile in some instances.

Record keeping related to prescription medications is a key part of the operation of a facility's health services program. **Business and Professions Code Section, 4232,** requires that pharmaceutical records, including inventories of those medications not used and therefore

destroyed, be kept for three years and, as noted above, drug companies require detailed records of unused drugs which are returned to them. The health administrator is responsible for overseeing medications and monitoring records of medications dispensed. Recording must be thorough, including reasons why a prescribed medication was not administered, (e.g., minor was in court, minor slept through pill call, minor refused medication, etc.). The more detailed the documentation, the greater protection it affords the facility's dispensing personnel.

Rapid turnover of facility populations and the resulting possibility of individuals being "lost in the system," as well as good medical practice, dictate that there be a policy that limits the length of time medication may be administered without further evaluation. Medication should not be administered over extended periods of time without routine follow up to assure medication efficacy, continued need for treatment and absence of complications. At a minimum, follow-up should be scheduled with the same frequency as is customary in the community for the particular condition and, given the destabilizing effects of the facility environment (e.g., changes in diet and exercise, situational stress, relative enforcement of medication compliance, etc.), more frequent medical visits are often warranted. The ordering of chronic medications for an indeterminate time (e.g., until release) fails to meet usual standards of care. For patients on stable medication regimens, follow up visits at least every one to three months is recommended.

For drugs with recognized abuse potential it is recommended that there be special consideration of "stop orders." With the high rate of substance abuse among the minors in the facility, it is essential that practices to discourage the development or continuation of drug dependency be incorporated into the prescribing habits of facility practitioners. Policies may need to include a requirement to reevaluate the need for habit-forming medications every seven to fourteen days.

There must be policy describing the length of time within which a physician's verbal orders must be signed by that physician. Signing of medical orders pertaining to the general medical care of minors should be compatible with community standards (usually 72 hours). In the case of psychotropic medications **(Section 1439, Psychotropic Medications)**, initiation of non-emergency therapy must include obtaining informed consent from the patient and/or parent/guardian by a qualified professional **(Section 1434, Consent for Health Care)**. As a general rule, the use of verbal orders is limited to minor aspects of care and cannot take the place of on-site evaluation and treatment. Review of the number and types of telephone orders is an important aspect of the quality review or management process **(Section 1403, Health Care Monitoring and Audits)**.

For stocks of controlled substances to be maintained in a facility, the facility must be registered with the Drug Enforcement Agency (DEA). If there is no qualified registered pharmacist, the responsible physician may use his or her registry number to obtain stock supplies of controlled substances, if the number is registered with the DEA for that facility. A physical inventory of controlled substances is required every two years, or more frequently at the demand of the Board of Pharmacy.

**Subsection (a)(8)** requires that a pharmacist must prepare at least annual reports on the status of pharmacy services in the institution. The importance of pharmaceutical management and related concerns are also incorporated into the monitoring procedures and annual reporting for internal

quality control in **Section 1403, Health Care Monitoring and Audits**. It is vitally important that any problems with regard to pharmaceutical management be discussed in the annual audit report. The Board of Pharmacy licenses pharmacies in some facilities and performs inspections that include a review of pharmacy services. When this occurs, the Board of Pharmacy report may be considered the annual pharmacist report for purposes of this regulation. The mismanagement of medications presents considerable risk to minors as well as liability to detention systems.

Automation of pharmaceutical records can provide some relief to a burdened manual record keeping system, especially in larger facilities. Automated record keeping increases the ability to monitor patterns of prescribing, to detect patterns of minors' requests for drugs and to monitor the efficiency of the pharmacy service. An automated record keeping system may reduce record storage problems, reduce retrieval time for patient medical histories, increase accuracy in record keeping overall and even make the monitoring of over-the-counter drugs easier.

**Subsection (b)(10)** requires policies and procedures related to OTC medications. This is intended to addresses concerns about lack of policy for what drugs can be provided (by licensed or non-licensed staff), potential over-use of OTCs, inconsistent documentation and lack of notification to health care staff when certain medications are provided to the minor. Frequent use of OTCs may mask symptoms of more serious health conditions that should be brought to the attention of health care staff. The OTCs made available and procedures for delivery may vary greatly among facilities. When there are no on-site health care services, policies may be considerably different from facilities where health care staff is accessible to evaluate requests on a 24-hour basis. Although it is cumbersome, it is recommended that the delivery of over-the counter medication be documented; this helps in the identification and referral of minors with chronic complaints that have not been evaluated, helps avoid untoward drug interactions or complications, and helps prevent hoarding and trading medications.

Detention facilities with full time pharmacy and medical staff may decide to maintain a "Pharmacy and Therapeutics" committee as part of their total quality management process. Included on the committee would be the responsible physician, a pharmacist, the director of nursing services and the director of mental health services. This committee should be responsible for developing written policies and procedures to establish safe and effective systems for the procurement, storage, distribution, dispensing and use of drugs. They would also develop and maintain a formulary of drugs for use throughout the local detention system. Using such a committee is an effective method of ensuring quality through the conduct of the annual audit of procedures, chart reviews and monitoring of prescription practices.

## Section 1439. Psychotropic Medications.

**The health administrator/responsible physician, in cooperation with the mental health director and the facility administrator, shall develop written policies and procedures governing the use of voluntary and involuntary psychotropic medications.**

**(a) These policies and procedures shall include, but not be limited to:**

**(1) protocols for physicians' written and verbal orders for psychotropic medications in dosages appropriate to the minor's need;**
**(2) requirements that verbal orders be entered in the minor's health record and signed by a physician within 72 hours;**
**(3) the length of time voluntary and involuntary medications may be ordered and administered before re-evaluation by a physician;**
**(4) provision that minors who are on psychotropic medications prescribed in the community are continued on their medications pending re-evaluation and further determination by a physician;**
**(5) provision that the necessity for continuation on psychotropic medications is addressed in pre-release planning and prior to transfer to another facility or program; and,**
**(4) provision for regular clinical/administrative review of utilization patterns for all psychotropic medications, including every emergency situation.**

**(b) Psychotropic medications shall not be administered to a minor absent an emergency unless informed consent has been given by the parent/guardian or the court.**
**(1) Minors shall be informed of the expected benefits, potential side effects and alternatives to psychotropic medications.**
**(2) Absent an emergency, minors may refuse treatment.**

**(a) Minors found by a physician to be a danger to themselves or others by reason of a mental disorder may be involuntarily given psychotropic medication immediately necessary for the preservation of life or the prevention of serious bodily harm, and when there is insufficient time to obtain consent from the parent, guardian, or court before the threatened harm would occur. It is not necessary for harm to take place or become unavoidable prior to initiating treatment.**

**(d) Administration of psychotropic medication is not allowed for disciplinary reasons.**

**Guideline:** The responsible physician, in cooperation with the mental health director and facility administrator, must develop policy and procedures governing the use of psychotropic medications. The involvement of the mental health director is essential to obtain their specialized expertise during policy development. Involving all key administrators helps to assure that there is consensus among clinical departments and facility administration, all of whom are involved in implementation.

A wide variety of drugs are now considered "psychotropic medications." The defining feature is the purpose for which the medication is given. For the purposes of this standard, psychotropic medications are those drugs whose purpose is to have an effect on the central nervous system to impact behavior or psychiatric symptoms. They include, but are not limited to anti-psychotic, antidepressant, lithium carbonate, anxiolytic drugs, and anti-convulsants or any other medication when used to treat a psychiatric condition.

Because child and adolescent psychiatry are specialized areas of clinical practice, and because poor prescribing patterns can result in adverse physical and social consequences for minors, it is

important to utilize clinical staff who adhere to recognized and accepted guidelines for use of psychotropic medications. Examples include those published by the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry. While a physician should order psychotropic medications, that physician may not necessarily be specialized in psychiatry. However, at a minimum, the facility should utilize a physician who is knowledgeable in the diagnosis and treatment of mental disorders, with additional understanding of their applications in child and adolescent patients. In general, psychotropic medications should be used only for those conditions known to be responsive to such treatment. They are never to be used as punishment or for simple restraint of undesired behavior.

Voluntary treatment of minors requires the informed consent of the parent (or entity with equivalent authority). Since the minor also has the right of refusal of any non-emergency care, he or she must also be agreeable to treatment.

Consistent with the philosophy described under **Section 1413, Individualized Treatment Plans**, the mere fact that minors take psychotropic medications should not automatically exclude them from participation in facility programs. Such minors should be allowed to participate unless the physician specifically orders a restriction based on additional rationale.

Only in the case of an emergency can a minor be treated with psychotropic drugs on an involuntary basis. Such situations are limited to those in which there is an urgent threat of serious bodily harm or death and it is not practical to seek consent. Because the administration of involuntary medications is a situation fraught with risks of over-use and/or adverse physical effects, this approach should be carefully monitored and reviewed for appropriateness. Consideration should be given to transfer of minors in need of such extreme measures to a licensed treatment facility, as discussed above under **Section 1437, Mental Health Service and Transfer to a Treatment Facility**. Long acting "depot" formulations of psychotropic medications are not considered appropriate for emergency treatment. Minors should be observed carefully following administration of psychotropic medication, to monitor changes in behavior and respond to any unanticipated reactions to the medication.

When a minor who takes psychotropic medications is transferred to another juvenile facility, it is important to assure that arrangements are made for timely continuation of the medication. All too often, lapses in communication during the transfer process result in discontinuation of the medication and decompensation of the minor's condition, ultimately resulting in disruptive behavior that is misinterpreted and leads to discipline rather than treatment.

In addition to the considerations above, policy and procedures should address time frames for re-evaluation of patients prior to renewal of medications, training of staff in recognition of adverse effects of psychotropic medications and procedures for arranging for discharge medications and follow-up at the time of release.

**Section 1450. Suicide Prevention Program.**

**The health administrator, in cooperation with the mental health director and the facility administrator, shall develop a written suicide prevention plan, with policies and procedures to train staff to identify minors who present a suicide risk, appropriately monitor their condition, and provide the necessary treatment and follow-up.**

**Guideline:** This regulation applies to all juvenile facilities and specifies the need for a written, organized approach to suicide prevention that addresses identification of minors at risk, monitoring and treatment, as well as staff training.

It is recognized that an interdisciplinary collaboration of supervision, medical, and mental health staff are important in optimizing suicide prevention strategies within juvenile facilities. In addition to identifying physical plant characteristics that provide opportunities for accomplishing suicide, there are significant risk factors that should prompt interventions to reduce suicide risk. This is particularly important in light of epidemiologic data revealing an epidemic of suicide in the 15-24 year old age group. Minors who are housed in adult jails and lockup facilities are at unusually high risk of suicide, as may juveniles upon whom severe sentences have just been imposed.

The suicide prevention program should address multiple levels of approach, beginning with the determination of physical plant characteristics that present hazards with respect to opportunities for self-harm. Identification of minors at risk, procedures for monitoring with an intensity consistent with the degree of suicide potential and referral for mental health care should all be included in the plan. A crucial feature of effective staff supervision is communication from one shift to the next about the status of a suicidal minor.

Consistent with **Section 1413, Individualized Treatment Plans**, pre-release planning may include advisement of parents/guardians of any unusual concerns about suicidal ideation at the time of release, as well as arrangements for mental health follow-up in the community. It should be noted that families often experience a significant degree of denial that interferes with their ability to perceive suicidal signals from a minor; consequently, input from juvenile facility staff may prove critically important in sensitizing family members to actual risk.

Training of both health care and supervision staff is integral to a successful suicide prevention program. Without it, recognition of risk factors and subtle indications of impending suicidal actions would go unrecognized. Particular attention should be paid to critical "high risk" times. These would include any time of significant transition, such as intake, pre-release, and sentencing. Consideration should be given to a specific screening/interview after sentencing, especially if the sentence was particularly severe.

With appropriate staff education and intervention, young lives will be saved and tragedy averted. Some key suicide risk factors identified in national studies follow and should be considered when providing suicide prevention training:

From the minor's perspective, there are certain unique characteristics of detention, which enhance suicidal behavior. These include:

1. fear of the unknown;
2. authoritarian environment;
3. no apparent control over the future;
4. isolation from family and significant others;
5. shame; and,
6. dehumanizing aspects of detention.

In examining potentially suicidal behavior, the following predisposing factors are commonly found:

1. recent excessive drinking and/or use of drugs;
2. recent loss of stabilizing resources;
3. severe guilt or shame over the offense;
4. same sex rape or threat of rape;
5. current mental illness;
6. poor physical health or terminal illness; and,
7. approaching an emotional breaking point.

The high-risk suicide periods correlate with phases of their incarceration or steps in the judicial process. These periods include:

1. the first 24 hours of confinement;
2. intoxication/withdrawal;
3. court and sentencing hearings;
4. impending release;
5. decreased staff supervision;
6. weekends and holidays; and,
7. bad news from home.

Signs and symptoms exhibited by the minor can foretell a possible suicide and, if detected, could prevent such an incident. What the individual says and how he/she behaves while being arrested, transported and/or booked are vital for detecting suicidal behavior. An individual may exhibit warning signs and symptoms that include:

1. depression (physical signs)
    a. sadness and crying,
    b. withdrawal or silence,
    c. sudden loss or gain in appetite,
    d. insomnia,
    e. mood variations,
    f. lethargy;
2. intoxication/withdrawal;
3. talking about or threatening suicide;
4. previous suicide attempts;
5. history of mental illness;
6. projecting hopelessness or helplessness;

7. speaking unrealistically about the future and getting out of detention;
8. increasing difficulty relating to others;
9. not effectively dealing with present, is preoccupied with past;
10. giving away possessions, packing belongings;
11. severe aggressiveness; and,
12. paranoid delusions or hallucinations.

Minors who report or have a known history of suicide gestures should be placed in housing that can be closely observed by staff until such time as they can be seen by mental health services staff. While not a substitute for close staff observation, it may be preferable to house some suicidal minors with other, non-threatening residents.

**Section 1452. Collection of Forensic Evidence.**

**The health administrator, in cooperation with the facility administrator, shall establish policies and procedures assuring that forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution are collected by appropriately trained medical personnel who are not responsible for providing ongoing health care to the minor.**

**Guideline:** This regulation applies to all juvenile facilities that have on-site health care staff and clarifies that such staff are prohibited from the performance of specific functions for the purpose of obtaining evidence for prosecution. While it is often tempting for law enforcement staff to seek the help of on-site health care staff in collecting certain specimens for evidence, the benefits of convenience are far outweighed by serious disadvantages.

When health care staff who provide treatment to juveniles are also used for assistance in prosecution, an untenable conflict in roles results. Minors subjected to evidentiary examinations by treatment staff are likely to develop mistrust that will interfere with subsequent therapeutic interactions.

Another conflict that arises from participation in evidence collection is competition for staff time. Demands for health personnel to perform evidence collection and examinations are compounded by ensuing requirements for related court appearances - all of which detract from their ability to effectively deliver health care services.

Alternatives for accomplishing necessary forensic functions may include use of a local emergency department or clinic that would not otherwise be expected to have an ongoing role in health care of the juvenile. Large facilities may be able to justify hiring or contracting with a medically trained individual who is separate from the treatment team. Facilities should consider the medical risks associated with some evidentiary procedures, such as body cavity searches, when deciding whether to arrange for on- or off-site examinations.

**Section 1453. Sexual Assaults.**

**The health administrator, in cooperation with the facility administrator, shall develop policy and procedures for treating victims of sexual assaults and for reporting such incidents to local law enforcement when they occur in the facility.**

**The evidentiary examination and initial treatment of victims of sexual assault shall be conducted at a health facility that is separate from the custodial facility and is properly equipped and staffed with personnel trained and experienced in such procedures.**

**Guideline:** This regulation applies to all juvenile facilities and specifies that procedures must be developed to address both the reporting and the examination and treatment of minors who are victims of sexual assault while in custody.

Sexual assaults raise serious medical, mental health and criminal issues. Statute **(Penal Code, Sections 11160-11161)** requires treating health care personnel to report such incidents to law enforcement. In addition, this regulation requires that policy and procedure call for the facility itself to report any sexual assaults that occur in the institutional setting. Separate statute **(Penal Code, Section 208.1)**, applies to minors held in jails, and requires that assaults of any kind be reported to the Board of Corrections.

Because a properly conducted sexual assault examination requires special training and knowledge of procedures that go beyond the capabilities of the ordinary juvenile facility, this regulation requires referral of victims to medical facilities that are adequately prepared to carry out this function. **Penal Code, Section 13823.5,** and **Section 13823.7** require the use of protocols and forms approved by the Office of Criminal Justice Planning when health professionals conduct medical examinations for evidence of a sexual assault. Hospital emergency departments are generally best prepared to perform sexual assault examinations.

Additional benefits are to be gained by referral of victims to such facilities. Removal of the minor from the juvenile facility may be perceived as a more treatment-oriented approach and will also introduce an important element of objectivity to the investigation of the incident. In addition, many communities have special sexual assault response teams that, in addition to providing an expert examiner, also offer added psychological support services to the victim.

Medical and mental health follow-up subsequent to the initial emergency evidentiary examination is essential. Nothing in this regulation precludes this from being provided by the on-site health services at the juvenile facility. It is, however, important for health staff to communicate adequately with the initial treatment team in order to assure that all necessary follow-up care is completed.

Consistent with **Section 1403, Health Care Monitoring and Audits**, instances of sexual assault are important to track internally. While such assaults are likely to be few in number, any trend suggesting an increase in rate should raise serious concern and prompt a review of supervision procedures in the facility.

**Section 1454. Participation in Research.**

**The health administrator, in cooperation with the facility administrator, shall develop policy and procedures governing biomedical or behavioral research involving minors. Such research shall occur only when ethical, medical and legal standards for human research are met. Written policy and procedure shall require assurances for the safety of the minor and informed consent.**

**Participation shall not be a condition for obtaining privileges or other rewards in the facility. This regulation does not preclude the collection and analysis of routine facility data or use of Investigational New Drug protocols that are available in the community. Neither does it prohibit blind studies of disease prevalence performed under the auspices of the local health officer. The court, health administrator, and facility administrator shall be informed of all such proposed actions.**

**Guideline:** This regulation applies to all juvenile facilities and clarifies the necessity of assuring that adequate protections for juveniles are in place whenever biomedical or behavioral research projects are considered.

While research can ultimately lead to significant benefits in the care of juveniles on a collective basis, there must be safeguards to protect individuals from undue risk and assure that their participation represents an informed decision based on free choice. It is also necessary to obtain consent of the minor's parent, guardian, or other legally responsible authority, and this should be obtained in writing for each participant. It is important that no special inducements or restrictions are offered or imposed by either the facility or study group in order to influence a decision to participate in a given project.

Review and approval of all proposed research studies should be obtained from an impartial review board that is experienced in the evaluation of study designs and ethical issues associated with human research. Such review boards are most often associated with universities and medical schools.

It is important to consider the perspective of the presiding judge when considering allowing a research study to take place within the facility. Although they may vary in approach to this issue, judges may wish to be apprised of any research being conducted, and some may even insist on ultimate approval authority over whether a project is allowed.

This regulation is not intended to prevent facilities from maintaining and analyzing data that is routinely collected for management purposes. The key distinguishing factor between ordinary data management and research is whether the juvenile's experience within the institution is somehow modified by virtue of the manipulation of a variable that is the subject of the study. This is most obvious when an invasive procedure, such as collection of blood, hair, or other samples is done. However, more subtle interventions, such as structured interviews or dietary manipulations, also constitute interventions which, when undertaken solely for the purpose of analysis within an organized study, must be evaluated for safety and appropriateness under this regulation.

Blinded disease surveillance studies conducted under the authority of the local health officer are not subject to this regulation. Such studies involve non-invasive assessments for the presence of diseases within populations without linking findings with individuals.

This regulation also does not apply to participation in Investigational New Drug (IND) protocols available in the community. Such studies offer significant advantages to individual participants. This is particularly true in the case of otherwise hopelessly ill persons who might be helped by access to new drugs that are offered only on the basis of an investigational protocol.